

AN EXPLORATION OF TEACHING AND LEARNING IN AN ISIXHOSA COMMUNICATIVE LANGUAGE SKILLS COURSE IN A MEDICAL SCHOOL

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COMPULSORY DECLARATION

This work has not been previously submitted in whole, or in part, for the award of any degree. It is my own work. Each significant contribution to, and quotation in, this dissertation from the work, or works, of other people has been attributed, and has been cited and referenced.

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Abstract

An exploration of Teaching and Learning in an isiXhosa Language Communication Skills Course in the UCT Medical School

This thesis reports on research conducted into the teaching and learning of an isiXhosa Communication Skills course as a Second Language (SL) at the University of Cape Town (UCT). The research was an exploration of an isiXhosa language teaching pedagogy with a particular focus on learning and teaching and the usage of isiXhosa in the isiXhosa Communications Skills classroom.

In doing this research, I wanted to know what could be the cause of these attitudes. Questions that need to be considered in developing this pedagogy are: What are the benefits of its usage in the classroom? What are the language pedagogies that the teachers are struggling with? The study was carried out with second year medical students. In this study, questionnaires were distributed to 63 research subjects. Four classroom observations were carried out and 12 students were interviewed.

I observed that teachers as a group had characteristic pedagogical styles and approaches. The teachers were using more teacher-centred method, relying heavily on the use of textbooks, focused more on the teaching of pure isiXhosa language and used less varied techniques of instruction and engagement. There was little evidence of learner-centred teaching and incorporation of more communicative, interactive lessons and activities that help students for speaking competence.

Students had strong positive attitudes towards learning isiXhosa communication skills. **The students' views from** the interviews and classroom observations point towards broadly issues of learning second language and pedagogy in learning and teaching. Students seemed to be concerned and frustrated with the fact that they cannot speak in isiXhosa with the patients. They felt that learning isiXhosa was essential for their future careers, and the ability to speak isiXhosa would be beneficial for their work. **The students' interviews reinforced the conclusions that I drew from the classroom** observations and yielded insights into how teachers teach a Second Language.

This research found that there is a need for a systematic program of professional development for teachers in theories of language acquisition, communicative competence and an inclusion of more recent theories of pedagogy in language education. Indigenous language teachers should try to enrich their teaching and develop their understanding of the language-learning issues of their students. They should work to incorporate more communicative approaches and more varied activities into their teaching and develop stronger frameworks for a cross-cultural understanding in the growing demand for university graduates to speak the official languages of their provinces.

Isicatshulwa

Uhlolo Lofundiso Nofundo Lwentetho Yolwimi LwesiXhosa eMedical School (kwiSikolo sobuGqirha)

Le thisisi (ingcamango ebhaliweyo engqinelwe zingxoxo) isixelela kabanzi ngophando olwenziweyo ekufundiseni nasekufundweni kolwimi lwesiXhosa njengolwimi lwesibini kwiziko lemfundo ephakamileyo, iyunivesithi yaseKapa. Uphando olu ibiluhlolo lwendlela ekufundiswa nekufundwa ngayo ulwimi lwesiXhosa. Olu phengululo lugxile kakhulu kubunzululwazi ekufundiseni, ekufundeni nakwindlela esisetyenziswa ngayo isiXhosa kwigumbi lokufundisela isiXhosa eso.

Intsusa yoluphando luluvo lwabafundi ekufundweni kwentetho yesiXhosa. Izimvo zabafundi ekufundweni kwentetho yesiXhosa zibengumcimbi oxhalabisayo kubafundisi besiXhosa. Ekwenzeni kwam olu phando ibukukufuna ukwazi unobangela wezizimvo. Iimpendulo ezifuna ukuqwalaselwa ekuphuhliseni ubunzululwazi ngokufundisa zezi: Yintoni inzuzo ekusetyenzisweni kwaso egumbini lokufundisela? Bubuphi ubunzululwazi bokufundisa ulwimi obusokolisa abafundisi besiXhosa? Olu phononongo lwenziwe nabafundi abenza unyaka wesibini kwezonyango. Amaphepha-mbuzo kolu phononongo asasazwe kubafundi abangama 63-ophando. Ulolongo lwenziwe kumagumbi okufundela amane nakubafundi abayi-12 ekuthe kwadliwana indlebe nabo.

Ndiqwalasele ukuba ootitshala, njengeqela banazo iimpawu, izimbo kwanendlela yobunzululwazi zokufundisa. Okunye endikufumeneyo kukuba ootitshala ngabo abasembindini nabathatha inxaxheba enkulu apha ekufundiseni, bakholose kakhulu ekusebenziseni iincwadi zezikhokelo, bagqalise ngamandla ekufundiseni ulwimi lwesiXhosa olumsulwa kwaye mancinci amathuba okusebenzisa ezinye iintlobo zobuchule zokufundisa ezinomtsalane. Ubungqina bokubasembindini nokuthatha inxaxheba kwabafundi buncinci kakhulu kwaye ababandakanyeki gqithi ekuthetheni, intsebenziswano yezifundo nomsebenzi ethi incede abafundi ekuthetheni ngobuchule, nayo iyalambatha.

Noxa abafundi baye babonakalisa ukuzithemba okuqinileyo ngokwezimvo zabo ekufundeni ukuthetha isiXhosa, abaqulunqi boludwe lwezifundo (**ikharikyulam**)

bekunye nootitshala abamelanga kuwasusa amehlo abo kumgqaliselo wezimvo ezigxekayo kwaye amanani omlinganiselo kufuneka acuthwe. Iimbono zabafundi ezithathwe kudliwano-ndlebe nophononongo lwasemagumbini okufundisela zikhomba ngokubanzi kwimicimbi exoxwayo yolwimi lwesibini lobunjingalwazi ekufundeni nasekufundiseni. Abafundi bakhangeleka bedanile kukufumanisa ukuba abakwazi ukuthetha isiXhosa nezigulana. Kodwa abafundi babecinga ukuba ukufunda isiXhosa kuzakubanceda ekuqhubeleni phambili kwimisebenzi yabo yengomso. Kwaye ukukwazi ukuthetha isiXhosa kobayinzuzo emisebenzini yabo. Udliwano-ndlebe lwabafundi jikelele, lutsalwe kumqukumbelo ofunyenwe kuphononongo oluveliswe yimbono ebonisa ukuba iititshala zilufundisa njani na ulwimi lwesibini.

Ikhona ke imfuneko yokuba kuxhotyiswe kwaye kuphuhlise ubuchule bomsebenzi wootitshala, iingcingane ezibhaliweyo zokuzuza ulwimi, ubuchule bokuthetha nezinye iingcamango ezintsha zobunzululwazi ezingayinzuzo kwimfundo yolwimi. Ootitshala bolwimi lwemveli (indigenous) mabazame ukutyebisa isakhono sabo sokufundisa nokuphuhlisa ukuqonda kwabo umxholo wemfundiso-lwimi lwabafundi babo. (Mayibesisiseko semfundiso/mayibeluphahla lwemfundiso yabo ukumanyanisa iimpucuko ezahlukileyo, bavelele zonke iinkalo ekuqiniseni umqondo wabo ngokwemfundo ekhulayo yabafundi abafundela izidanga beyunivesithi ekuthetheni iilwimi zasebuRhulumenteni kumaphondo abo.

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An exploration of Teaching and Learning in an isiXhosa language Communicative Language Skills Course in a Medical School.

Chapter 1: Introduction

Background

A **doctor's daily duties** include consulting with patients. The patients bring their own life situations, emotions, and expectations about how they want to be seen by a doctor **to the medical consultation**. Engel (1998) writes that one of a doctor's many tasks is to know and understand their patients' medical conditions, respect their 'double needs', and show that they recognise and understand their personal situations. This is one of the core skills that future doctors need to acquire in their training. "Skillful communication **with patients is a central aspect of a doctor's professional identity**" (Lumma-Sellenthin, 2013:1).

The medical school of the 21st century is faced with the task of moulding medical students into competent doctors who are able to function in a scientific, technological and a racially, linguistically and culturally diverse environment. Therefore, doctor training requires the health practitioners to know much about their patients in the public service, whose language and cultural background usually differs from the majority of doctors in private service. In response to these requirements, many medical faculties include programmes to introduce medical students to additional subjects like language communication skills (Fazel and Aghamolaei, 2010). This is seen as an opportunity for improving communication skills which are helpful in establishing a good doctor-patient relationship and understanding patients as a human beings. It **is hoped that exposure to language subjects will influence students' attitudes** (Marambe, 2012) and make them more confident to meet and interview patients in their own languages.

Language communication programmes will also help to improve students' understanding of the patients and teach them interpersonal skills that cannot be learnt from books.. Acquiring a communication skill that recognises the patient as a person

and responds to the patient's complaints in an empathetic way is a complex task compared to the pure acquisition of factual knowledge. Some skills can be taught, but others cannot be. Students experience Xhosa second language training for **doctor's consultations** as a challenge. This can cause worry to the students and in the worst case scenario **result in student's attitude** to learning a second language (Rees and Garrud, 2001). According to Hayden and Lumma (2007:18), in addition to its function of imparting values, the development of language communication skills involves more **complex learning processes that are based on students' reflections and evaluations of their behaviour**. This is because professional language not only comprises certain **terminology, but also "the use of language for professional purposes, for instance the posing of inquiring questions, the explanation of medical facts, and the structuring of interviews"** (Hayden and Lumma 2007:38). However, the attitude of students towards learning communication skills in second languages is not always positive (Lumma-Sellenthin, 2013)

Hence the aim of this study is to explore and examine the teaching and acquisition of isiXhosa language communication skills at the University of Cape Town (UCT) medical **faculty. It seeks to describe UCT medical students' acquisition of communication skills**, the difficulties they encounter and the coping strategies they use. The study will also look at the way the isiXhosa Communication class is taught by the teachers.

In the institutions around South Africa there is a growing demand for university graduates to speak the official languages of their provinces. In the Western Cape, isiXhosa, Afrikaans, and English are the official languages. Therefore it makes sense to learn these languages for professional communication reasons. In 2003, the University of Cape Town introduced Afrikaans and isiXhosa courses for occupation-specific purposes. The decision to introduce these courses was firstly informed by the Language Policy for Higher Education (2002), which stated that there must be increased access to learning and information. It also stated that teaching needed to promote African languages, using socio-culturally relevant curricula, to develop these languages for academic use. This decision was also informed by the belief that the

new generation of health care professionals should be equipped to serve in multilingual communities.

Official Languages in the Western Cape were given formal approval by the Constitution of the Western Cape, 1997 (Act 1 of 1998), which requires learners and medical students to learn Afrikaans and isiXhosa as a second language. It was also important that students in the Faculty of Health Sciences acquire isiXhosa proficiency for professional purposes in the communities around Cape Town. Although Afrikaans and isiXhosa are the languages dominant in the Western Cape besides English, most students still perceive isiXhosa as a foreign language because of the difference in physical locations, social spaces and culture between themselves and the people who speak it (Kese, 2012). As a result, the knowledge of isiXhosa by other dominant language groups in the Western Cape such is inadequate as a resource for social transformation and nation building (Western Cape Language Audit, 2001).

When the UCT School of Languages and Literatures and the Faculty of Health Sciences **started to promote and implement the university's vision of multilingualism** in 2006, it was apparent that there would be some challenges. The challenges were probably inevitable, given the comparatively low level of development of isiXhosa and the fact that just fifteen years ago there was no isiXhosa teaching for professional purposes at UCT. The UCT Language Policy was only formed in 1999 and approved in 2003. isiXhosa was only taught to students who had teaching interests in their future career. It was therefore not developed as a tool to help students in communication for specific purposes in their professional careers.

The literature has identified the existence of both positive attitudes and negative attitudes as additional challenges in the establishment of these programmes. Marambe (2012:165) mentioned some **factors affecting the medical students' attitudes toward** learning communication skills, such as "previous educational experiences, age, gender and communicative ability". According to Somhlahllo (2009:58-59), **"African language** departments tended or tend to focus their courses on comparative linguistics, and phonetics, whilst neglecting the important area of applied linguistics and **communication skills"**. She states that it is crucial that the Department of Education

changes the curriculum so that it accommodates studying isiXhosa for the interests and needs of the working environment in the outside world. However, a lack of material and trained second language practitioners for African languages contributes to the lack of language teaching in the UCT medical school. As Heugh (1993:30) notes, **“it must be clear that the lack of material and trained human resources in virtually all the indigenous languages in South Africa will inevitably restrict the extent to which tuition can be offered in those languages”**.

1.1. A brief history of the introduction of Afrikaans and IsiXhosa in the Medical curriculum at the University of Cape Town

According to Rammala (2002), language plays a very important role in the process of transformation of education systems. It can help to transform students socially by promoting communication, promoting tolerance and facilitating development. This means that language can act as the tissue that binds people and this can help with socio-psychological factors and attitudes. Attitudes affect the social distribution of languages in a particular context. In South Africa for example, many languages are associated with particular ethnic groups. Language policy and planning can help transform the community for educational purposes, and language can be used as an instrument of meaningful access to community.

Soon after the first democratic election in South Africa in 1994, the new government embarked on a process of radical transformation of the higher education and healthcare sector to rectify the mistakes of the past, in order to create equal distribution of languages to the educational sector. In 2013, still not many strides had been taken in this direction. The Western Cape is home to approximately 5 million inhabitants. The census (2001) found Afrikaans to be the most commonly spoken language in the Western Cape, used by 49.70% of its inhabitants. It is followed by 24.72% who speak isiXhosa and 20.25% who speak English as a mother tongue. According to the census statistics, Blacks and Coloureds are the dominant groups in this province. Most of them are uneducated and live below poverty margins. This means that the majority of people cannot access basic services such as basic health needs due to various factors such as living far from where services are offered, the

inability to access information about availability of these services, or because of the competing basic needs such as food and proper shelter. The majority of them still prefer the traditional way of medical consultation due to the language barrier.

Although isiXhosa is the second most common language spoken in the Western Cape, it is still not extensively used for professional purposes. Crawford (1999:27) pointed out that **“the majority of doctors in hospitals do not speak isiXhosa which is spoken by majority of isiXhosa patients’ speakers”**. **This is supported by Levin (2005:9) who said “Incorrect pronunciation of isiXhosa names in the hospital waiting rooms led to delays, sometimes nurses are unwilling to interpret.”** These researchers were trying to establish whether isiXhosa patients might be dissatisfied with doctor-patient consultation compared to their counterparts who are English and Afrikaans speakers who are not really affected by language related issues.

Although measures have been put in place to improve the situation many teachers are still not well trained in current methods and pedagogies of second language teaching, and doctors still speak little or no isiXhosa at all. Sometimes the ‘doctors use nurses to translate, but they are not professional translators, information can be inaccurate, and nurses are not always available to translate and interpret’. This is **bound to have consequences for diagnosis and treatment, and thus the patient’s well-being**. Crawford (1999) argues that doctors are still linguistically ill-equipped to care for isiXhosa speaking patients, whose numbers continue to grow rapidly as people move from rural areas. Williams (2006) also highlighted the fact that, as a result of **language barriers “isiXhosa patients tend to relate positively when they consult with a health professional who understands or speaks their language” (2006:7)**. Enhanced communication skills and thus effective interactions among the members of the health community and patients are essential, and hence the UCT Health Faculty introduced the teaching of second languages in their medical curriculum.

In August 1994 the Faculty of Medicine in the University of Cape Town, which later was renamed as the Faculty of Health Sciences, adopted a policy on the Primary Health Care approach in order to equip its graduates with the values and skills necessary to

meet the changing demands of the new national system (Irlam & Vivian, 2009). This policy **"committed the Faculty to make the Primary Health Care approach central to its teaching, research, clinical service, and engagement with communities"** (Irlam & Vivian, 2009:3). Medical students were introduced to social science and psychological theory, cultural competence and bio-psychosocial aspects of patient care. This approach was integrated into medical education internationally, and UCT followed suit in order to give equal service to all South African inhabitants. Irlam & Vivian (2009) **mention that this approach is the core of the 'people-centred' medical ethos** in South Africa, because it takes cognisance of the diversity of languages, cultures, customs, belief systems and family structures which are characteristics of its communities. Students are taught how to apply these approaches with their patients during the first three years of the curriculum and in the fourth year they experience public health rotation, where they are placed at different community based sites (Irlam & Vivian, 2009).

The change in the curriculum aimed to produce graduates more fit for service in a post-apartheid South Africa, where the collapse of social and geographical boundaries meant that people were not confined to previously demarcated racial and cultural areas. According to Seggie (2010:8), **"this curriculum demanded the training of graduates who would combine preventive, promotive, curative and rehabilitative care in their practice and who would be able to help any patient "**. **These doctors would** acquire knowledge and skills enabling them to practice with confidence at multiple levels of health care in the restructured South African public health system. For example, at the Primary health care level, the patients are largely non-paying and therefore from low income groups who are predominantly uneducated and need doctors to be able to be isiXhosa proficient when they consult with them.

Therefore, courses like 'Clinical Skills' were added to the curriculum, which involved the facilitation of communication and providing basic care to the patient's needs and problems, identified by effective listening. The General Medical Council (2009) provided guidelines for clinical skills, which include:

- Health information is shared in appropriate cultural and language terms.

- Amount and level of information given is appropriate.
- A suitable environment is fostered to communicate with the patient and/or family.
- Patient feedback and questions are facilitated.
- Confidentiality is ensured.
- **Basic counselling skills addressing the patient's needs are demonstrated.**
- Appropriate solutions are explored.
- Mutual decision-making is facilitated.
- Continual support and follow-up is provided (General Medical Council, 2009)

General clinical skills also require competencies in communication skills in second languages like isiXhosa, and Afrikaans. However, the shortage of properly skilled second language teachers remains a problem in this area. Most teachers tasked with teaching this to students lack an adequate second language pedagogy. In combination with a perceived lack of motivation to learn isiXhosa from the students, it is a challenge to integrate the teaching of isiXhosa into the clinical skills course component, and it is difficult to measure the real-life effectiveness of such courses.

isiXhosa Second Language Teacher Training

According to Somhlahlo (2009), most African language teachers have not received training in language acquisition theory and practice, and coupled with a lack of pedagogical language instruction, this results in a serious teaching barrier. The absence of teacher service training or availability of workshops that integrates language for academic purposes with pedagogical studies and teaching practice is the most worrying aspect in African language teaching training. According to Pludderman *et al* (1998), language development programs are not in **place to improve teachers'** pedagogic knowledge and provide them with skills to help teachers meet second language teaching standards. In the past teacher training education focused on training for first language students. Now, there are a few courses organised by the isiXhosa Second Language Curriculum Development designed for second language teachers.

1.2. Rationale for this study

“Successful second language learning entails complete personal, intellectual and emotional participation and involvement of the learner”. In recent years researchers such as Bilash (1999) have explored factors affecting second language learning, and their significance. Much responsibility for teaching isiXhosa as a second language has been placed on regular classroom language teachers, and not skill specific instructors. However, little training is being provided to help them. Milner (2010:9) argues that in these times of change, preparing teachers for diverse classrooms is more than a challenge; it is a duty. According to Dewing (2012), it is the “responsibility of teacher education programs to provide service training for teachers with the rigorous preparation necessary to meet the second language demands of practising medical professionals” (2012:8).

Although the need to teach isiXhosa for professional-specific purposes in tertiary education has been established, the actual practice of teaching these courses has highlighted problems. Teaching directly from manuals and student rote-learning is the norm. Students are often frustrated and bored, and as a result lack enthusiasm for and commitment to learning isiXhosa, despite the fact that isiXhosa is the key to some professional areas like medicine, law and social work. (UNESCO, 2008). Hence Moon (2000:2) suggests that a language should be made **“attractive and accessible and cool”** in order for students to be interested in speaking and learning it. He says that **“to force students to learn a language is likely to backfire and have the opposite results to what is intended”**.

Therefore this research is an attempt to examine some of the gaps and problems in isiXhosa language teaching and learning practices at UCT more closely. It aims to understand the various issues the UCT medical students have towards learning isiXhosa, to examine the kind of teaching and learning that takes place in the classes, to see what can be done to improve isiXhosa second language teaching and learning at a tertiary level, and to examine the challenges faced by teachers and students in integrating isiXhosa into medical clinical skills.

1.3. Brief Outline of Chapters

A brief description of the chapters of the thesis is as follows:

Chapter One: Introduction and Background to the Study

The first chapter gives a general introduction to the rationale behind doing this research in the Medical School and the teaching and professional experiences that led me to undertake this study. This chapter also presents a historical review of the development of language teaching in medical school, and the current situation of isiXhosa teaching in tertiary education.

Chapter Two: Literature Review

This section reviews the literature pertinent to the issues of teaching and learning of Second Language Pedagogy, and Language Attitudes in the Second Language teaching context. This chapter gives the theoretical framework for the study and surveys the current research in second language teaching in various contexts, as well as key themes in the literature about second language acquisition and learning.

Chapter Three: Research Methodology

This section presents the qualitative methodology and the data collection methods used in the study. The data were collected from classroom observations of four teachers and interviews with students from four different classes at the UCT medical school.

Chapter Four: Data Analysis

Chapter four presents analysis of classroom surveys, observations, interviews, and the manual used for teaching.

Chapter Five

Discussions, recommendations and conclusion

This section presents the discussion of the findings and their significance in relation to current debates about Second Language pedagogy in relation to isiXhosa teaching.

Chapter Two: Literature Review

Introduction

This section presents the discussion of second language teaching and learning literature. The first part of the literature review will be focusing on themes in acquisition and learning of language in general. The second part will look at second language pedagogy and attitudes to language learning. It will focus on language attitudes and the importance of language learning medical context, especially in doctor-patient consultation. Lastly, it will look at designing a manual for second language learning and teaching.

For centuries, there were hardly any theoretical foundations of language learning upon which to base teaching methodology. According to Brown (2001), second language learning in schools in the West resembled the learning of Latin. Latin was taught by means of what has been called the Classical Method, i.e. focus on grammatical rules, memorization of vocabulary, conjugations, translation of texts and doing written exercises (Richards & Rodgers, 1986). The teaching of Latin aimed to provide intellectual challenge and develop logical thinking, rather than to equip students to use the language. Later, this came to be known as the Grammar Translation Method which focused on grammatical rules as the basis for translating from the second to the native language.

Grammar Translation was the most commonly used method until it was replaced by the Direct Method (Stern, 1983) and then by the Communicative Approach (Littlewood, 1983) in Western countries. The use of this method resulted in extensive dissatisfaction in second language classrooms, because it does not encourage speaking, it focuses more on language structure (Husna, 2009). Pedagogy seems to be the problem for the majority of second language teachers in SA schools and universities, especially those that are teaching African languages (Greiger and **O'Connor**, 2009). A new teaching approach in second language instruction which replaces grammar translation is Communicative Language Teaching (Krashen, 1982).

In the following section I will look at theories pertaining to second language teaching and learning. After that I will also look at second language pedagogy and explain the relationship between theory and practice in a second language classroom. I will highlight language attitudes and how they can influence learning and teaching. Lastly I will look at the importance of language in medical context.

2.1. Language Learning and Language Acquisition

Krashen (1982) makes a clear distinction between language learning and language acquisition. South Africa has been long linked to the traditional approach of language study generally practiced in second language teaching. In the traditional approach, where a language is consciously learned, attention is focused on the language in written form. And the objective is for the student to understand the structure and rules of the language. The key feature of this approach is the emphasis on accuracy as being of greater importance than communication which focuses on fluency. Students have to develop a solid understanding of grammar and linguistic form in the absence of practical usage.

Language acquisition, on the other hand, “refers to the process of natural assimilation involving intuition and subconscious processes”, according to (Krashen, 1982:21). Here the student is an active participant using the second language in the production of real interactions. This form is reflected in the principles of a communicative language teaching approach because students develop familiarity with characteristics of the language including its structure and vocabulary, for example, *hlala phantsi* (sit down), *phfumla* (breathe), *lala ngomqolo* (lie on your back).

Theories about how second languages are learned and acquired have multiplied over **the last four decades. For the purposes of this study I have focused on Krashen’s** (1982) Monitor Theory and Affective Filter Hypothesis as well as theories of **Communicative Language Teaching (CLT) (Nunan 1991, 2004) and Brown’s Principles of Second Language Pedagogy (2001)**. These three sets of theories are the most

influential in terms of current pedagogical thinking and are foundational to the field of Second language teaching methodology (Vogt, 1998:6).

Krashen's Theories of Language Acquisition and Learning

In the early eighties, (Krashen, 1982) published his five hypotheses about second language acquisition: **'The acquisition – learning distinction', 'the natural order hypothesis', 'the monitor hypothesis', 'the input hypothesis' and 'the affective filter hypothesis'.** The acquisition-learning distinction is one of the most extensively researched hypotheses. It states that adults have two distinct and independent ways of developing competence in a second language. The first way is *language acquisition*, a process similar to the way children develop ability in their first language. Language acquisition is a subconscious process; language acquisition develops naturally in the context of social communication. The second way to develop competence in a second language is by *language learning*. Learning refers to conscious knowledge of a second language and being aware of language rules (Krashen, 1982:10).

The acquisition-learning hypothesis claims that adults acquire language just as children do. This hypothesis claims that **"the ability to 'pick-up' languages does not disappear at puberty as once thought"** (p.10); however, this does not mean that adults will always be able to achieve native-like levels in a second language, as most children can do. **Krashen's theories of language acquisition suggest that child and adult learners learn primarily through subconscious processes of 'picking up' the new language,** which suggests that maximum immersion in a second language would be advantageous. His input hypothesis has also been foundational in theorizing about the **teaching of second languages (Husna, 2009).** **'Input' refers to language which is understandable by the acquirer.** The acquirer needs to hear and understand input that is easy to follow. The situations where acquisition occurs are when the input is comprehensible (Krashen, 1982:21).

In order to help second language acquirers, teachers use 'modified input', sometimes called 'teacher talk' or 'inter-language talk'. Modifications made in 'teacher-talk' are usually used for the purpose of communication and to help second language acquirers

understand what is being said. **'Teacher-talk' input is roughly tuned** to the level of the acquirer Krashen (1982: 25). The input hypothesis predicts that these modified codes **will be useful for second language acquirers. "The hypothesis also predicts that** natural, communicative, roughly tuned and comprehensible input have some real advantages over finely tuned input that directly attempts to teach the structure of the **day"** (Krashen, 1982:69), and **not every utterance contains the target structure. For example, if the lesson's focus is the present tense marker, other tenses** will be used as well in both classroom input and in the readings (Krashen, 1982).

Krashen (1982:5) states that language acquisition does not require extensive use of conscious grammatical rules. Real language acquisition develops slowly and speaking **skills emerge later than listening skills. In fact, there is a 'silent period' in which the** child or adult first language learner builds up competence in the second language by listening. The learner may say little during several months of exposure to second language in a natural, informal, linguistic environment. Silent periods allow learners to learn chunks of language/expressions and phrases before they start talking (Krashen, 1982:6-7).

However, adults and children in formal language classes are not allowed a silent period. They are often asked for language output in the second language, sometimes even before they have acquired enough syntactic competence to express their ideas. According to a hypothesis first proposed by Newmark (1966, cited in Krashen, **1982:27), performers who are asked to produce before they are "ready" will fall back** on first language rules. They will use first language syntactic rules while speaking the second language.

Communicative Language Teaching (CLT)

The fundamental principle of communicative language teaching is that in order to develop language ability, learners must be engaged in doing things with the language. **This approach relies heavily on the student's ability to interactively negotiate meaning,** with linguistic forms acquired incidentally during the process. This form calls for new roles for teachers and students, that is, instead of relying on activities that demand

accuracy, repetition and the memorization of sentences and grammatical patterns, students are required to negotiate meaning through interaction in the second language.

Here are a few principles of CLT (Nunan 1991, cited in Butler 2005:424:

- A focus on communication through interaction
- Use of authentic materials
- Focus on the learning process as well as the language itself
- **Belief that learners' own experiences can contribute to learning**
- Linkage between language learning in the classroom and real-life activities

Therefore CLT builds on a pedagogical approach to language teaching and incorporates ideas of acquisition and builds on motivation. CLT focuses on interaction as vital to learning a language to understanding the meaning and the ability to communicate. According to authors such as Canale (1983), Brown (2001), Nunan (1991, 2004) and Littlewood (2007), CLT focuses on language as it is used in real **contexts i.e., language for "real life" communication. The students are given** opportunities to use language, express their ideas and opinions in a real life situation. The teacher acts as a facilitator during classroom activities. This form requires that the teacher must first lay a solid foundation of language skills, then these students will be equipped with adequate tools to generate spontaneous language use inside and outside the classrooms boundaries. While CTL instruction has a tried and tested framework for implementation in some learning contexts, such as the school and classroom, patient-centred communication instruction still poses challenges.

Until now, no approved standards have existed for the instruction of patient-centred communication teaching. But in teaching language certain methods are common among teachers and they tend to use traditional forms of language teaching. In communicating with patients, medical students need a language that will help them to provide better clinical care to their patients. Language skills go beyond gathering information, they also build a solid relationship between the student doctor and the patient. In other words, the idea behind language communication skills training is to improve communication performance between student doctors and patients.

For that reason, CLT seems to be the most apt method in teaching second language communication skills for doctors. When students are learning a new language they always look for the similarities with their own languages (Bilash, 2009). Now when such similarities are non-existent, as is the case with isiXhosa and English, new strategies need to be developed to minimise difficulties in learning isiXhosa. Strategies and language rules for learning isiXhosa are different from European languages. Approaches such as Communicative Language Teaching and Task Based Language Teaching (Bilash, 2000) make use of tasks and activities that engage students in pragmatic, authentic and functional use of language for meaningful communication, and these may be more appropriate for teaching medical students where conversation **is viewed as vital. Chambers (1997, cited in Brown, 2001:43) writes that “a great deal of use of real language is implied in CLT and TBLT, as they both attempt to build fluency in speaking”. Accuracy and acquisition of the formal features of the second language are less a measure of successful language learning than are fluency and an ability to get something across comprehensibly to a second language speaker (Sanders, 1987: 222, cited in Beale, 2002: 15).**

According to Littlewood (2007), there was a significant change in the language teaching approach over the seventies and eighties once CLT replaced the grammar translation method and audio-lingual methods. Teachers are meant to be less dominant in the classroom and develop more friendly relationships with students whereas the older methods were hostile.

CLT can also assist in peer learning or self-learning because students can assess their language proficiency and at the same time gain self confidence in processing information with little help (Littlewood, 2007). This will result in independent learning and better production. For a teacher, in order to facilitate competence in students, he/she has to first put in place all the language tools students need; they have to understand, practice and later produce the language. As Beale (2002:13) suggests, **teachers have to follow the teaching sequence, ‘presentation, practice and production’ (PPP).** This sequence aims to assist a teacher to gradually produce more independent learners who take varied and increasingly independent roles in classroom interaction.

For example Presentation means that, before teachers expect students to use a language or structure, it must be presented to them. Therefore, teachers need to provide students with a variety of examples and situations that will give them the input they need to be able to use language productively. Practice means that teachers must present the information that they want their students to learn but before they expect them to use it productively they must give them ample of opportunities to practice it. Practice is the last step before testing for learning or acquisition levels. Production means that having presented the language that teachers want students to learn and given them opportunities to practice it, they may now justifiably expect them to produce it, to use it in actual conversations and different situations. Teachers are seen more as guides and facilitators than as controllers of everything that happens in classrooms.

According to Johnson (1980), the traditional teaching methods such as audio-lingual and grammar translation methods which are centred around the demonstration of grammar rules and language structures, where teachers spend a substantial amount of time explaining on patterns, and rules does not help students much. CLT techniques help because teachers use more communicative exercises.

Cheng (1980:62) states that "CLT activities focus on students' interaction with their peers". Group activities maximize the amount of oral interaction on the part of the students. Students are also less likely to be self-conscious when working with their peers. The teacher moves from one group to another without being intrusive. She/he gives guidance and help only when needed. CLT not only encourages the above activities but also emphasizes the use of visual aids, like cards and power-point displays. Role-play and communicative games are also part of CLT features that can be arranged for group work and pair work. Students usually enjoy these kinds of tasks because they can be fun and in addition develop students' communication skills. The five features of CLT outlined by Nunan (1991:279) strengthen good practice in developing the learner's language competence. The five features are:

- An emphasis on learning to communicate through interaction in the target language.

- The introduction of authentic texts into the learning situation.
- The provision of opportunities for learners to focus, not only on language but also on the learning process.
- **An enhancement of the learner's own personal experiences as important** contributing elements to classroom learning.
- An attempt to link classroom language learning with language activities outside the classroom.

These features are based on the idea that the learner is the central focus of language **teaching and learning processes and so the emphasis must be put on the students'** needs and interests. The basic pedagogical principle of CLT is that successful acquisition of the target language on the part of the learners depends on the amount of interaction and negotiation of meaning that they participate in. In this way, the integration of language input and output contributes to the language development system of the learners (Beale, 2002:15).

2.1.1. Ways in which Bilash applies Communicative Language Teaching (CLT)

In this section I will use Bilash (2009) to illustrate Communicative Language Teaching and Learning. I choose Bilash because she covers most aspects of language learning, acquiring and teaching second language especially those related communication competency.

According to Bilash, (2009) when learning a second language there are five components that need to be taken into consideration, namely:

- **Personality component:** this component includes anxiety, self-esteem, attitudes, and competitiveness. All these are the factors whose degree and existence apply much influence on the success of language learning.
- **Learner's belief: this component refers to what second language learning involves.** Once a student has belief that there is a need to learn the language, he or she would be motivated to learn. The best way of learning is by memorising the language.

- **Teacher's belief about language learning:** this refers to the teacher's ability to teach and to encourage learners to learn the language.
- Interaction between the learner and the teacher: this involves how the teacher motivates students to talk, and classroom organisation that creates an environment for students to be comfortable in speaking, asking questions and practising newly acquired/learnt language.
- Processes, assessments and events in the class: difficult assessments with unclear or unfamiliar instructions can create anxiety and negative attitudes toward learning. leading to

In explaining second language teaching, Bilash (2009:2) gives an example of a tree, and explains that a tree is a helpful unifying device which links theory and practice of observing a second language class. In explaining her tree below, a teacher needs to know that the class is a whole tree. The branches represent what the student needs to learn, the trunk represents what the student brings to the learning context and the roots represent the theories to be considered in teaching.

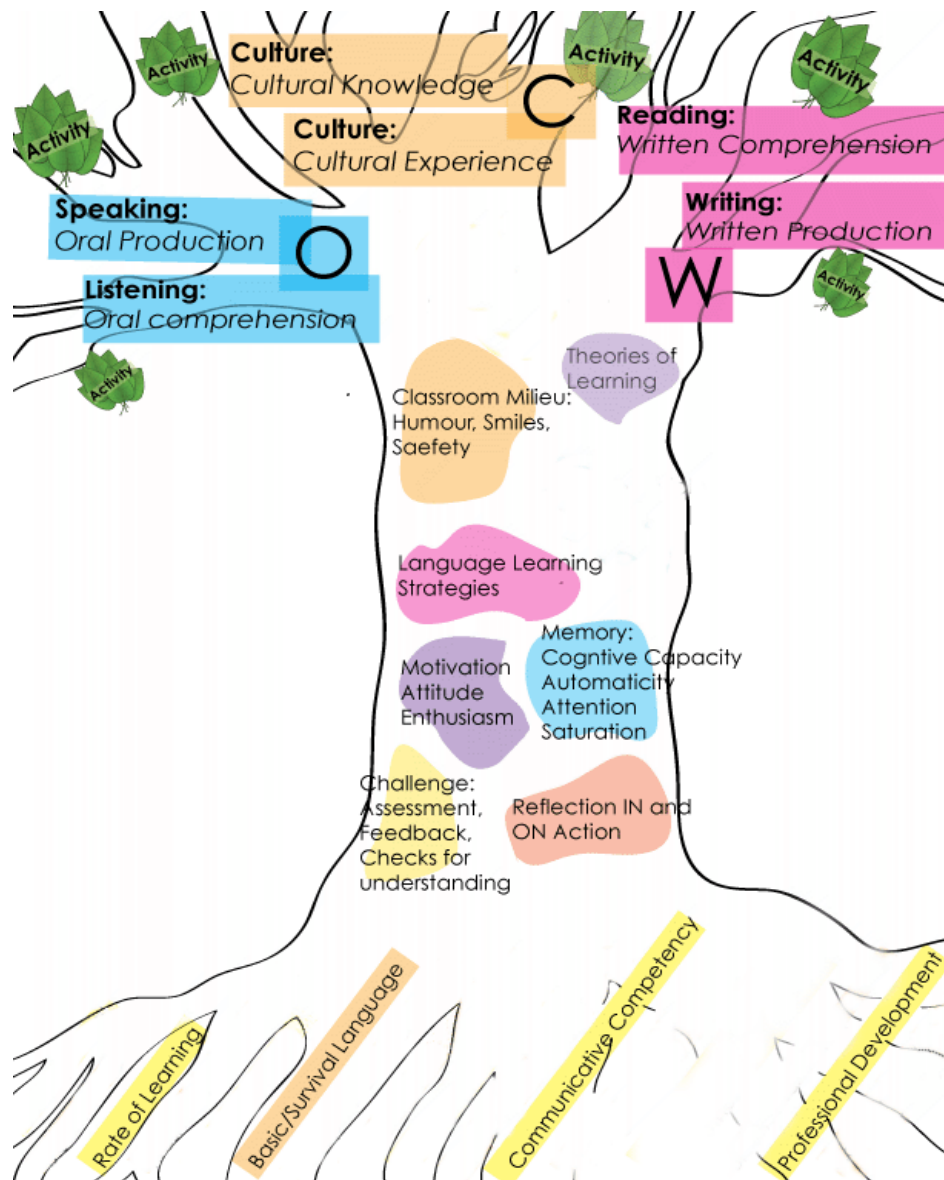


Figure 1: Bilash's Schematic sketch in teaching and learning a second language.

The tree is organized in a way that helps us understand and monitor the activities that should be followed in a second language classroom. The tree has three parts. The branches represent activities in the second language classroom. In learning a second language the branches remind us that when we plan for oral development we are considering the development of listening skills and speaking skills. In developing written language skills we must pay attention to the teaching and practice of reading and writing skills. The tree also reminds us that in learning another language, students

learn another culture. The trunk represents the ways in which the students learn and experience the classroom. Each knot on the trunk represents different theories of learning. The roots represent a selection of theoretical ideas to be considered when teaching a second language.

In the next section I will focus on four issues on the tree roots, namely, the rate of learning, professional development, communicative competency and basic and survival language.

a) *Rate of Learning*: One major question that should be in the minds of teachers when they are ready to teach a language class should be how long it takes to learn another language. It is useful to ask this question because learning a language is a complex process that is different for every learner. It is complex because there are many factors that need to be considered. Bilash mentioned (2009:14) that as a teacher you need to be aware of factors like individual differences, differences in languages, exposure to the language and goals of the learner. According to Bilash, (2009:15) **"the rate of learning depends largely on the individual"**. Bilash (2009:15) mentions individual differences in language learners in language learners and how these differences relate to the good language teacher. The factors she mentions for teacher consideration include age, gender and background knowledge. The rate of learning also depends on the differences of the language being learned and first language. It is also greatly affected by the amount of exposure to the language they are learning. If students do not get exposure their rate of learning decreases because the classroom is the only space in which they get primary input to learn the language.

b) *Professional Development*: **To achieve growth the profession, part of the teacher's responsibility is to develop the students' second language capacity. The success and failure of any education initiative regarding language use for specific purpose depend on interconnected personal and pedagogic factors. The teacher becomes the bridge that facilitates a positive interaction of personal factors e.g. attitudes, motivation and pedagogic e.g. syllabus design and teaching techniques.**

c) Communicative competency: Most utterances are for a specific purpose, whether we are apologizing, expressing a wish or asking permission, we use language in order to fulfil a variety of needs. Students also use the language in order to fulfil a specific purpose therefore making them competent in communication is their goal and should **be a teacher's goal. Teachers could do that** by giving the students a language ladder, in the form of basic and survival language.

In the next section I describe these two forms of language, Basic and Survival language.

d) Teaching Basic and Survival language in learning Second Language: In creating resources for a second language classroom, it is important to know the basic and survival language. **"Survival language is the language that one can use in certain situations"** (Bilash, 2009: 30). **It is to learn how to be conversant in practical situations.** Survival language consists of the words and phrases encountered in daily situations, where a learner will need to negotiate a situation, for example, verbs of request/motion, and the language of the classroom and consultation between doctor and patient (Bilash, 2009: 30). **"Basic language would include many of the categories or themes a second language speaker has been exposed to"** (Bilash, 2009: 30). It is quite common that in certain situations students require basic language for communication but in other situations survival language. Students will need to possess both basic and survival language, as they are likely to encounter situations that require **both in the course of days' work. In other words, survival language is where one can** just learn vocabulary for specific situations, whereas basic language, one needs to understand all aspects of learning a new language. In selecting to teach or expose students to a new language a number of factors should be considered. It is often said that you start from zero point and gradually build the vocabulary as the students move forward. A vocabulary of 300-500 words is the start for beginning communication (Bilash, 2009:32).

Survival language learners need to develop both survival language and basic language. Categories for basic language learning for example should include greetings, food, clothing, family members, interactional phrases, questions, description verbs of

motion and verbs of request. Survival language, on the other hand, should include phrases relating to giving and getting instructions, rules and playing games like vocabulary cards. This aspect of language is as important as the basic language, one needs to know how to develop both language skills in order to use them in times of need.

Bilash's (2009:33) tree also depicts the importance of culture in learning a second language. When learning second language there's always an aspect of culture that is intertwined in the language, in other words you cannot teach one without the other one. According to Deumert (2003:33), although the majority of doctors saw absence of a common language as the main barrier to successful communication, some medical staff expresses a preference for a 'cultural explanation' of the problems they encountered when treating isiXhosa patients. Thus, communication break-down is not seen primarily as a consequence of their inability to speak patient's language, instead patients are seen as being 'culturally different' (2003:33).

As discussed in the next section, Bilash gives four significant skills that are important in a classroom if students are to be successful in learning a second language.

2.1.2. Bilash's Four Skills Activities in Second language classroom

As one can see in the Figure 1, the four skills activities are the significant activities that are highlighted as core learning in a second language classroom (Bilash, 2009). The four skills are reading, speaking, listening and writing. These skills help teachers to give their students well-rounded development in all areas. Through daily activities teachers must provide learners with opportunities to use each skill in the classroom, for example,

- Listening: the students can listen to the teacher using the target language, in a song, or to one another in a group activity.
- Speaking: this is the most important skill of them all; the students can develop pronunciation, greetings, dialogue creation, and role playing.
- Reading: skills like grammar, understanding and following instructions are developed through reading.

- Writing: sentence construction, phrases and dialogue script are also developed through writing (Bilash, 2009:2).

Bilash (2009) points out that in most cases teachers find it difficult to incorporate the four skills together. In order to use these skills together effectively, Nunan (1999:4) recommends task-based instructions that use tasks or activities which require comprehending, producing, manipulating or interacting in the target language. Bilash (2009:9) argues that the amount of listening, speaking, reading and writing involved in the completion the task is dictated by the task itself. Task-based instruction helps learners to explore a multitude of communication opportunities provided in their task. The tasks themselves need to be scaffolded according to cognitive demand required to complete them and can be carried out individually, in pairs or in small co-operative groups. A teacher cannot know how much students know or have learned until they are given opportunities to speak.

Why is speaking important?

In the four skills mentioned above, oral production is the most valued by students, but teachers often find it a skill that is hard to develop (Bilash 2009). Brown (2001:7) **writes that “speaking plays a crucial role in oral communication, as it is used to convey one’s ideas and to express one’s feelings in a simple way”.** Therefore, in order to communicate with a first language isiXhosa speaker, you need to be able to produce the language, and construct meaningful utterances.

According to Bilash (2009:4) the goal of language is communication and the aim of speaking in a language context is to promote communicative efficiency; teachers want students to actually be able to use the language with a purpose. Hence students often value speaking more than the other skills. However, what often happens is students feel more anxious about their oral production. Second language learners value communication competency because it is where they meet communicative goals. **Brown (2001:228) states that “speaking is valuable because that is where the learners’** strategic competence is used, the ability to know when and how to keep a conversation going, how to terminate it, how to clear up communicative breakdowns

as well as comprehension problems". As speaking is interrelated with the other skills its development results in the development of other skills. One of the primary benefits of increased communicative competency is to increase strategic competency.

Therefore, according to Bilash (2009) when planning speaking activities teachers need to decide whether students need *high structured* language, e.g. difficult complex vocabulary for practice in learning or *low structured* language, e.g. role playing, and simulations. It is advisable to inform the students of the areas below, so they are aware of the purpose of the activities (Bilash 2009).

- Strategies: this area involves the different pieces that make up speaking, including pronunciation, vocabulary, grammar and word order.
- Functions: this area describes the uses of speaking, whether for transaction or interaction, and when precise understanding is or is not required.
- Social/cultural rules and norms: this area involves the more subtle cultural value **inherent in the language's culture, such as good manners, roles of participants** and social register.

All the above suggestions are valuable for a learner, but a teacher must have a strategy to give all this information to the students. They need to be provided in small amounts – which Bilash (2009) refers to as scaffolding.

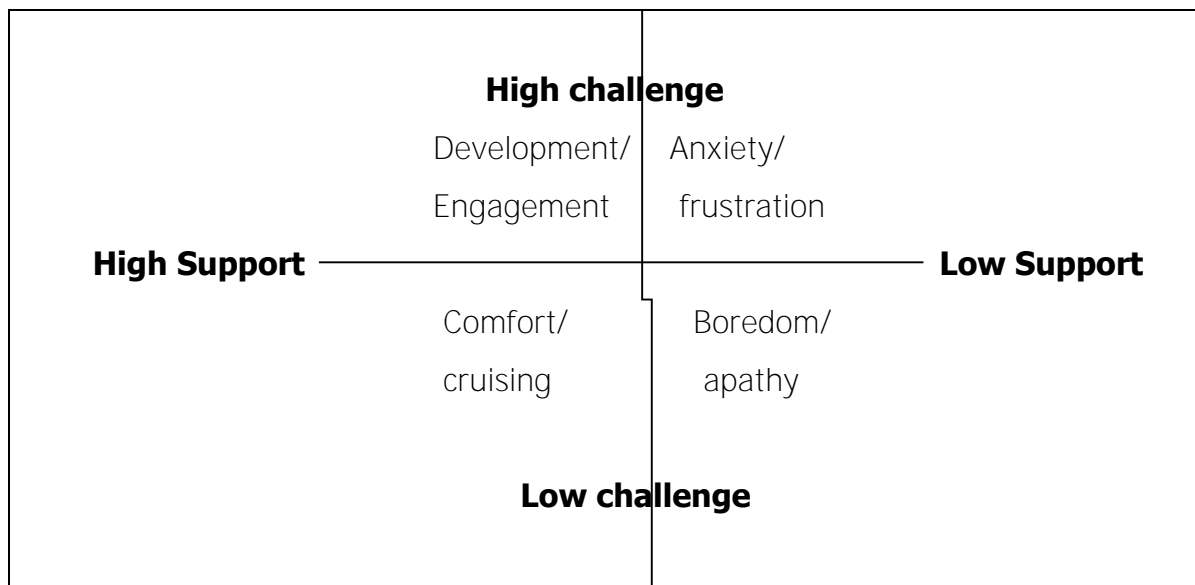
In the next section, I discuss the concept of scaffolding in second language learning. I will begin by giving definitions and then discuss what is specific about the concept.

The idea of scaffolding in second language teaching

Maybin, Mercer and Stierer (1992) write that **"scaffolding can be seen as a particular type of mediating, task-based dialogue that is built into tasks, provides students with the knowledge and strategies necessary to achieve a new language" (1992:188).** Scaffolding helps to bring the learner toward a state of competence which will enable them to eventually complete a task on their own. This helps the learners to internalise the new knowledge and skills for eventual use in other tasks (Applebee, 2002).

In trying to understand “scaffolding as a task-enabling support in a teaching-learning environment”, Mariani (1997:23) gives the teaching style framework below, which shows how classroom teaching practices and routines structure students’ experience of their learning environment by creating different degrees of challenge and support. The figure below describes events and emotions that happen to students when a teacher facilitates a second language class.

Figure 2 Mariani’s 1997 teaching style example



Mariani explains that students experience classrooms as zones of anxiety/frustration when a teacher provides high challenge activities to students who are not ready for this challenge (1997). If a teacher gives the students enough scaffolding support in the beginning, a student could excel at the same high challenge. Mariani refers to this as the development/engagement situation. In other words, when an exercise is challenging to students, they need maximum support in order to get the best possible outcome. In another classroom, students could experience low support and low challenges, which would put them into the boredom/apathy section. When students are given the best support but not enough opportunity to practice, they miss opportunities to learn more (comfort/cruising). On the other hand, if they are given low support and challenging exercises, they could be frustrated and may drop out

through frustration (Mariani, 1997). A good teacher needs to make sure that the support she gives to her learners is balanced with the challenges given to them.

Using Mariani's framework in my study might help teachers at the UCT medical faculty recognise that the majority of students who enter the faculty have few to no isiXhosa skills. These students are thus placed in a 'high challenge' situation, which may only lead to failure and reduction in the student's motivation.

The model draws attention to learning behaviour and the way in which learning develops over a period of time for each of the teaching-learning zones. Teachers have a strong position of control and responsibility for this learning. Scaffolding then can also be understood as assisted accomplishment of new or difficult tasks.

Wei describes scaffolding as a pedagogic activity, whereby it is the 'infrastructure' or support that the master gives to the apprentice, or the teacher plans for the student, for tackling the task at hand (cited in Maybin, Mercer & Stierer, 1992:188). This means that the teacher is seen as "constructing a structure that represents her cognitive abilities" (Wei, 1999:198). Language learning should start from the ground up, on the foundation of what is already known. New vocabulary is built on top of old vocabulary. The teacher has to provide this scaffold to support the construction, starting from known territory into unknown territory.

Scaffolding as language mediated guideline

Vygotsky (1978) argues that language has a privileged place in the development of higher human consciousness because, as the 'tool of tools' it is used by humans to act on, control and transform their social skills. In the classroom, in particular the second language classroom, it is the "cultural toolkit that acculturates students into ways of thinking and speaking. The students will use the language of the community to which they aspire to achieve" (Mercer, 2002:10). In any classroom, the teacher-student dialogue is the most important mediating tool used to guide individuals to understand the tasks given (Wells, 1999). Participation in such dialogue affords students opportunities to acquire new ways of speaking and improve their attitudes towards learning a language.

Teaching successfully is not an easy task. Teachers are instructed by their respective curricula to achieve certain outcomes, but how those outcomes are achieved is up to the teachers. Therefore, the technique of scaffolding is useful in teaching a second language. Some students need more scaffolding than others. Tasks and activities can be broken down into achievable chunks for the students. Simple chunks make students gain confidence in their abilities. Too much anxiety or pressure could lead students to develop a negative attitude towards learning the language. Krashen (1982) writes that as soon as a student feels a task is too difficult, they stop attempting it. Therefore **students' current language knowledge should be used as a foundation to support new knowledge**. Ideally the new information should be placed at a level just above the **knowledge the students already possess, as proposed in Vygotsky's Zone of Proximal Development (ZPD) (Vygotsky, 1978).**

Vygotsky's Zone of Proximal Development

According to Vygotsky (1978:88-9), **the Zone of Proximal Development is "the distance between developmental level as determined by independent problem solving and level of potential development as determined through solving under adult guidance or in collaboration with more capable peers"**. In this way ZPD is related to scaffolding through working in small groups. To promote student success in learning second language, teachers may use specially structured small groups often in their lessons, giving students time to interact with their peers. Some students are able to perform certain tasks better under teacher guidance or with peer collaboration (through realisation of their potential).

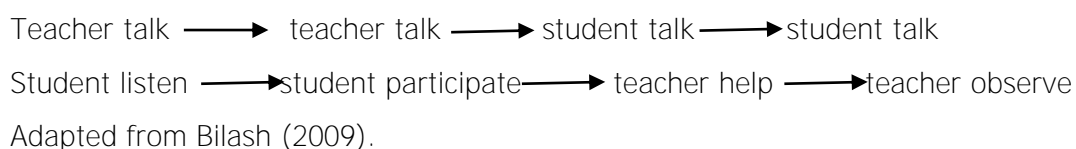
Here are some additional suggestions teachers can use when scaffolding and using groups:

- To provide clear directions in order to minimize student confusion
- Simplify the task so that the students can apply themselves
- Involve students in their learning process

These ideas encourage a teacher to create additional resources and materials to meet this challenge. Many second language teachers struggle to find resources that are both appropriate and meaningful to their students. This is especially the case for

language teachers, especially languages that are not developed to the level of English or Afrikaans. Figure 3 demonstrates ways of assisting learners through their Zones of Proximal Development.

Figure 3 Modes of scaffolding



The diagram above explains the stages the teacher should follow when teaching an unfamiliar and difficult task in meaningful contexts while helping students as much as the teacher can. In the learner-centred approach, the teacher will talk through what the learners need to understand and how to go about understanding the topic. The first step in the example is for the teacher to engage the student in the task, with the student participating. The second step is for the student to take over the task by using **the teacher's strategy, with the teacher helping and intervening as needed. Finally,** the student independently uses the strategy and the teacher observes. The teacher can pair students together so that students who understand the task better may help students who are struggling. With students who are still struggling, the teacher may have to provide help, or repeat the task. In other words, the teacher has to provide the scaffolding to support the student.

Language learning styles and learning strategies in the in the teaching context

According to Oxford (2003:1), "language teaching and learning styles and strategies are among the main factors that help determine how and how well our students learn **a second language**". She suggests that **a second language should be learned in a calm environment which is also conducive to interaction among students.** . The learning styles and strategies of the teachers and students remain pivotal in making this **exercise interesting and successful. By learning styles, Oxford means the "general approaches, for example, analytic, auditory or visual that the students use in acquiring a new language"** (2003:1).

Cornett defines learning **styles** as “the overall patterns that give general direction to learning behaviour” (1983:9). These include specific behaviours, actions, steps or techniques that learners use to enhance their language learning, such as seeking out conversation partners, or tackling a difficult language task (Bilash, 2009). Oxford (2003) writes that if there is harmony between learning style, learning strategies and instructional materials, then the student is likely to perform well, feel confident and experience low anxiety. If there is a clash between learning styles and learning strategies, the student often performs poorly, feels unconfident, and experiences significant anxiety. Oxford concludes by saying that these clashes may also lead to the **discouraged student’s** outright rejection of the teaching methodology, the teacher and the subject matter.

2.2. Pedagogy

In the next section I will discuss techniques and specific actions that teachers can use to encourage learning in a second language classroom. I will start this section with the role of the teacher in teaching and learning.

Pedagogy has been defined as “the study of methods and the principles, practice or profession of teaching” (Hedge & Whitney, 1996:121). A more recent definition refers to the relationships, **social contexts and ‘hidden agendas’ of teaching and learning:**

Pedagogy is about the processes and dynamics of teaching and learning, including the purposes, management, underlying philosophy, relationships, curriculum, instructional methods, environment and social context of learning (Sanguinetti, Waterhouse et al.2004).

The role of the teacher in a second language classroom

There is no learning without teaching. Therefore, as a tool of implementing teaching plans and achieving teaching, the teacher plays a vital role in language learning. Nunan (1991) points out that a teacher is of crucial importance, not only for the organization of the classroom but also for the processes of acquisition that happen in the classroom. In terms of acquisition, “the teacher is probably the main source of comprehensible target language input the learner is likely to receive” (Nunan,

1991:12). The teacher therefore needs to be competent in the language, while also **increasing a student's self-confidence**.

Stern (1983:500) **writes that a language teacher needs to bring to the classroom "a language background and experience, professional training as a linguist and teacher, previous language teaching experience and more or less formulated theoretical presuppositions about language, language learning and teaching"** (. **The strategies a teacher uses need to create interest in learning a second language. Learners' contributions toward learning tasks can promote learner interest** (Stern,1983). Success from students can also promotes positive attitudes and perceptions towards learning a new language...

Encouraging the Use of Group work in Second Language Classrooms

Theory and research suggest that second language students can learn more effectively if they spend some of their time in and out of the class using the second language with classmates (Krashen, 2011). Through group learning, classmates often build friendships and feel comfortable interacting with each other and are more likely to interact with each other in the second language than with second language speakers. This friendly, low-risk, low anxiety environment can promote learning (Kimura, 2011). Another way for students to interact in their second language involves them studying in groups. Group learning is an area in general education that provides teachers of all subjects, including second language, with insights into how to successfully facilitate student to student collaboration (Jacobs & Kimura, 2013; Johnson & Johnson, 1999; Slavin 1995). These insights deal with such matters as how to encourage all group members to participate and learn individually, learn accountability and how to build a feeling of mutual concern and support within the groups.

However, simply asking students to work together will not always lead to successful interaction among students. One problem that often arises when second language students work in groups is that they spend most of the time communicating in their native language, and not in the second language. Thus why a teacher needs to facilitate the groups and assist when required. The most frequent reason why group

learning activities fail is that students lack the second language and other skills necessary for doing the task that their groups are attempting. When we begin using group work, the tasks should be a little bit too easy so that students can become comfortable and confident in using the group. Group work techniques like writing, thinking, or drawing allow students to prepare what they will say in second language.

Every type of task, whether individual, in pairs or groups has its place in the language classroom. Group work is a strategy the teacher needs to take into consideration to **promote a faster rate of learning. Bilash (2009:6) also points out that “encouraging students to develop their own strategies is an excellent means of stimulating the learner to develop tools for interaction”.**

The table below breaks down the benefits of using group work. It also assists teachers to see how interaction can take place in a second language classroom and the importance of interaction in determining learning opportunities. The table below is adapted from Bilash (2009) to show how group work can be used in the second language classroom.

Table 1: Students’ benefits, challenges and suitability of group work.

Student work	Benefits	Challenges	Suitability
Individual	Students work at their own pace, they are confident about what they know and what they don’t know. They use their preferred learning styles and strategies.	Students do not get the benefit of learning from their teachers and working with their peers.	Final tasks must be suitable for student’s ability.
Pair work	Students have the chance to work with and learn from their peers, struggling students can learn from more capable peers; it is especially useful for students who prefer	If students are not matched up well, pair work won’t be useful; the ability of the students to work in this way needs to be taken into consideration	Giving activities to students and students getting the activities

	interpersonal learning settings		
Group work	Group work provides more opportunity for practice, an increased variety of activities is possible, increased student creativity, the Zone of Proximal Development increases.	As with pair work, the groups must be carefully selected to ensure students can work productively, not all students are able to work to their full potential in this situation, assessment of student progress can be challenging.	Giving activities to students and students getting the activities

Table from Bilash (2009:.44)

To promote second language learning and to help students become comfortable communicating in it, classroom use of the second language should be understood, encouraged, promoted, and praised. Appropriately planned group activities not only assist learning but they also facilitate gains in affective variables, such as self-esteem and interethnic relations (Johnson, Johnson & Stanne 2001, Slavin 1995). As mentioned earlier, an essential concept in group work learning is positive interdependence, the feeling among group members that what helps one helps all, and that anything to the detriment of one member is detrimental to all members. Second language teaching and learning strives to bring people closer together and to facilitate recognition of our common interests.

Table 1 also demonstrates that there are certain benefits and challenges to each approach, but all of them can be connected to the theories of effective group learning. Some activities may be best suited to one particular style of work, but the key is to use a variety, and give students sufficient opportunities to work and learn from one another. Once the class is given enough time to practice and talk about the topic, it is always helpful to ask questions. The questions help to assess their understanding of the previously learnt topic. Their confidence in answering questions will be a good indicator of whether they understood the topic and you can move to the next area of learning.

The importance of asking questions

Questioning is one of the most common strategies used by teachers, and serves as the principal way in which teachers control the classroom interaction. Questions **perform specific assessing functions in the language class.** "Existing knowledge is a powerful determinant of how new information will be learned, and that often student misconceptions and beliefs always **interfere with learning new material**" (Chaudron, 1988:18). Through strategic questioning, the teacher can assess the current state of student thinking, identifying not only what students know but also the gaps and misconceptions.

The questioning of students in a classroom can be grouped into three broad areas, **according to Chaudron (1988).** Firstly, questions can be used as a "diagnostic tool and, that the classroom questions can allow the teacher to see glimpse into the mind of students to find out not only what they know or don't know but also how they think about the topic" Chaudron (1988:17). Secondly, questions play a role in helping students learn new material and integrate it with old material. In this case questions provide an instructional role in the practice and feedback essential for development.

The third function that questions perform is a motivational one. Through questions teachers can engage students actively in the lesson, challenging their thinking and posing problems for students to consider. According to Chaudron (1988:18), from a **lesson perspective, a question at the beginning can be used to "capture students' attention and provide focus for the lesson at hand."** Above all, frequent and sporadic questions can encourage active participation and provide opportunities in the lesson for continued student involvement. Also, questions can be used to draw inattentive students back into the lesson. When students make mistakes in their answers, teachers need to provide positive feedback in order to maintain motivation.

Teacher's Feedback

Without doubt, students will make mistakes in the process of learning. As Brown (2001:205) states, **"a learner's errors are significant in that they provide to the teacher evidence of how language is learned or acquired, what strategies or procedures the**

learner is employing in the discovery of the language". Correction helps students to clarify their understanding of meaning and construction of the language, but it is crucial that it is done gently (Bilash, 2009). Teachers have to be careful when correcting, because if they do it in an insensitive way, the students may feel upset and lose their confidence to speak in the class.

Assessment refers to the "tools, techniques and procedures for collecting and interpreting information about what learners can and cannot do" (Nunan, 2001:22). In assessment, the learner is informed how well or badly he or she has performed. However, when teachers assess students, they should not forget that the purpose is to help and promote second language learning. Therefore, teachers should be approving, confirming and encouraging in their feedback. Bilash (2009) writes that **it is important that students don't feel that their language output is constantly being assessed.** This encourages participation and communication, rather than focusing on accuracy.

Likewise, when teachers are doing assessments in the classroom, short or long term projects can make students personally involved in the language learning process and increase motivation. In the case of medical students, the teacher could design interactive exercises that are in line with consultation of patients, which is a core feature in language learning for these students.

Issues related to pedagogical challenges are not uncommon in second language **learning and teaching contexts. Research by O'Connor and Geiger (2009) shows that** the major problems faced by second language teachers in the Western Cape are:

(a) Lack of training and second language knowledge: this is significantly associated with the frequency of problems experienced in the classroom. Teachers learnt through their own gathered experiences about teaching, and wanted more formal, practical training.

(b) Lack of resources: Almost all teachers expressed the need for specific language teaching resources for teaching second language learners.

(c) Lack of support: the teachers felt that their needs are not being heard and met. Nobody seems to help the teachers, the department cannot help them and the **teachers must come up with their own strategies (O'Connor & Geiger, 2009:8-9).**

It is important for second language teachers to constantly evaluate their teaching, **bearing in mind that isiXhosa linguistic structure is different to the students' first language structure.** Kese (2012) writes that learning the content for isiXhosa is totally **different from student's home languages, perhaps because of cultural differences and histories, world views and philosophies.** Although isiXhosa has borrowed some words from both Afrikaans and English, there are otherwise no linguistic links between these languages. They are not related in any way; they are non-cognate. Mascher (1991:3) **defines cognate languages as "belonging to the same family of languages and so have similar grammar and vocabulary because they share common origins and a common history whereas non-cognates can borrow some words but not grammar". In short,** when a teacher designs materials for non-speakers of African languages, these structural differences should be one of the central considerations.

2.3. Language Attitudes

This section concentrates on types and formation of attitudes along with a brief definition of the concept of attitude in second language learning.

Definition of attitude

Fishbein and Ajzen (1975) define an attitude as the general feeling ranging from positive to negative, or an evaluation of good and bad that a person has towards themselves, other people, objects or events. Ellis (1986:293) refers to attitudes as **"sets of beliefs possessed by learners about such factors as the target language culture and the learners' own culture". In the case of classroom learning, students would have attitudes towards their teachers and the learning tasks they are given, which influence language learning in many ways.** Wilkins (1978:52) suggests that when learners **"have little intrinsic interest in language learning"** or they **"are not volunteers, the teacher must himself stimulate and sustain motivation"**. However Lightbown (2000) argues that if the learner's only reason for learning a second language is external pressure,

and internal motivation is minimal, so general attitudes towards learning may be negative. He goes on to mention that "depending on the learners' attitudes, learning a second language can be a source of resentment" (2000:39).

According to Kanjira (cited in Ellis 1994:473), the learner's attitude towards the target language informs the determination with which the learner tackles challenges in the target language. Normally, learners manifest different attitudes towards the target language, including the target language speakers and their culture. They develop attitudes towards the social value of learning the target language, assessing the potential uses of the target language, and examine themselves as members of their own culture. Kanjira continues to argue that learner attitudes have an impact on their level of second language proficiency and are in turn influenced by this success. Similarly, learners' negative attitudes may be reinforced by lack of success. Askes (1988:11), says that "effective learning can only take place when the learner is keen to acquire knowledge, he must therefore be strongly motivated".

Krogh (cited in Kanjira 2008) writes that the need to communicate comes from inside the learner, while the norms of society give shape to the communication. Krogh goes on to say that "language learning is easy when it's whole, real, and relevant, when it makes sense and is functional, when it's encouraged in the context of its use, when the learner chooses to use it" (Kanjira 2008:32). Kanjira (2008:33) also says that "the good language learner takes and creates opportunities to practice what has been learnt while a poor learner passively does what is assigned him".

Furthermore, research has revealed how attitudes are formed in the process of learning a second language. Gardner (1985:49) claims that *forcing* students to learn languages rapidly creates feelings of failure, and such dissatisfaction could generalize to attitudes toward learning the language among some students. Krogh (1990:111) also points out that "if language learning is not meaningful to learners, it is only a matter of time before their normal curiosity and excitement becomes dulled by the need to accomplish the teachers' requirements. By then the curriculum belongs to the teacher, not to the learners, and what started as a learning adventure becomes

increasingly work-like. It's easy for a teacher to fall into a pattern of dull, lifeless **exercises for learners**". Gardner (1985) proposes that there are three different experiences associated with second language learning that can have an influence on a student's attitudes and motivation. The first experience includes bicultural programmes, a regular language course and intensive language training. He says that:

"If teachers are skilled in the language and attuned to the feelings of their learners, and the methodology is interesting and informative, this can do a lot towards the awakening of positive attitudes, regardless of whether student's initial attitudes were positive or negative. Obviously, if teachers are not knowledgeable, not sensitive to student reactions, and weigh down with dull and unimaginative methodology, it is unlikely that positive attitudes will develop" Gardner (1985:105-6).

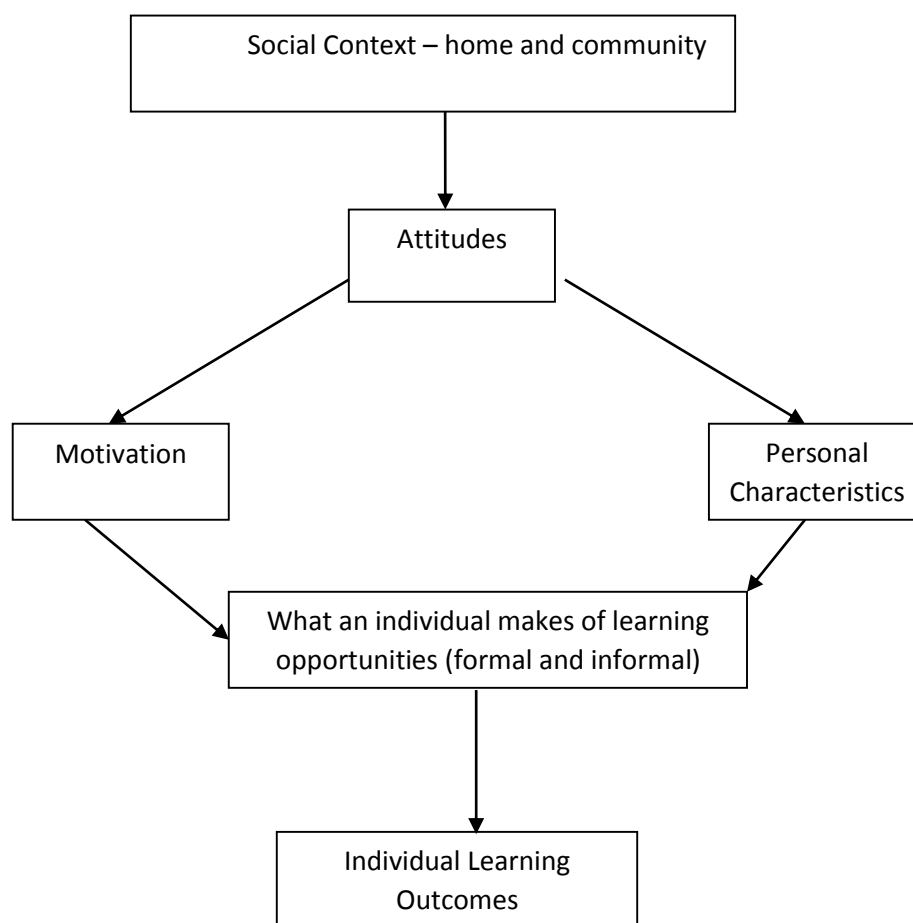
For that reason, the emotional climate has a bearing on motivation and attitudes in a learning situation. McDonough (1981:77) notes that **by "emotional climate"** he means the complex nature of the learning atmosphere in the classroom, which is created by the teacher and the pupils and through which the teaching and learning operates. The ways in which the language is typically used in the classroom is very important because the dynamics of the language classroom might have an impact on learners' motivation and the development of attitudes to the learning.

Another challenge in teaching a second language seems to be the lack of opportunities for learners to practice, in the localities from which they come. Material resources are hard to find, and thus teachers and learners need to be resourceful and innovative to find substitutes and variations. This can affect the standard of material that the learners use to acquire their second language skills. McDonough (1981:77) points out that it is a commonplace that most language classrooms are artificial and one sense of this term (non-genuineness) implies that the classroom does not reflect the eventual language-using situation. For this reason there has been for some time a trend towards a greater degree of realism in the classroom. If the students are taught language skills poorly, they are likely to develop negative attitudes towards languages.

Attitude formation

Students' attitudes towards a second language can be explained by Spolskys' framework (Brown, 2000 cited in Ghazali 2008:3) in Figure 4.

Figure. 4 Spolskys' Attitude Framework



According to Spolsky's framework,

- (i) attitudes are shaped by the **social context**, namely, an individual's home and community.
- (ii) These social context constitute formal and informal learning contexts, and according to (Ghazali 2008:3) Attitudes are often shaped by the social context, **"develop early in childhood and are the result of parents and peers' attitudes"**

(Brown, 2000: 180) as well as contact with others from different cultures. Attitudes towards a language, such as whether a language is considered worth learning, often begin at home. Social context also determines provision and practice for second language learning at home. Families that have positive attitudes towards language for example, might provide reading materials and practice in an informal learning context.

Students with positive attitudes will spend more effort to learn the language by using strategies such as asking questions, volunteering information and answering questions (Baker, 1993). Attitudes therefore affect the rate of development and the final proficiency achieved in the target language. Fortunately, attitudes do not remain static; they can be changed through the learning process such as by using appropriate materials and teaching techniques. Attitudes also improve as a result of language learning as learners who learn well will acquire positive attitudes.

- (iii) Both motivation and personal characteristics influence how an individual make use of learning opportunities in formal and informal contexts (Ghazali 2008:3). Research shows that all these social factors can have impact in language attitudes but I think my experience of teaching African Languages has shown constant motivation plays a big part in learning a language. If students are motivated, they could develop more positive attitudes than negative.

Brown (2000:180) argues that “attitudes are often shaped by the social context where they are developed in early childhood and are a result of parents and peers attitudes” as well as contact with others from different cultures. Attitudes towards a language, such as whether a language is considered worth learning, often begin at home (Ghazali, 2008). The social context also determines provision and practice for second language at home.

The attitudes are shaped by home and community attitudes which in turn, influence student outcome. Positive attitudes can be expected to enhance learning, since students can be expected to want to communicate with the native speakers of the language they are learning. Negative attitudes on the other hand, can impede

language learning, but the attitudes can change once learners realise what a good advantage it is to know the language.

An example is the medical students and students from other countries in Western Cape who value personal enrichment, will have positive attitude towards isiXhosa and will facilitate these attitudes in their homes as well.

Attitudes are learned predispositions by one's indirect exposure to a culture or a group through various media elements and other sources that may not be reliable. According to Herr (1949, cited in Seker, 2003) certain features that may have a role in attitude formation are: families with emotionally toned ideas very early in life, schools fostering attitudes to respect languages with lower status, and the press, as a powerful tool for creating and controlling attitudes.

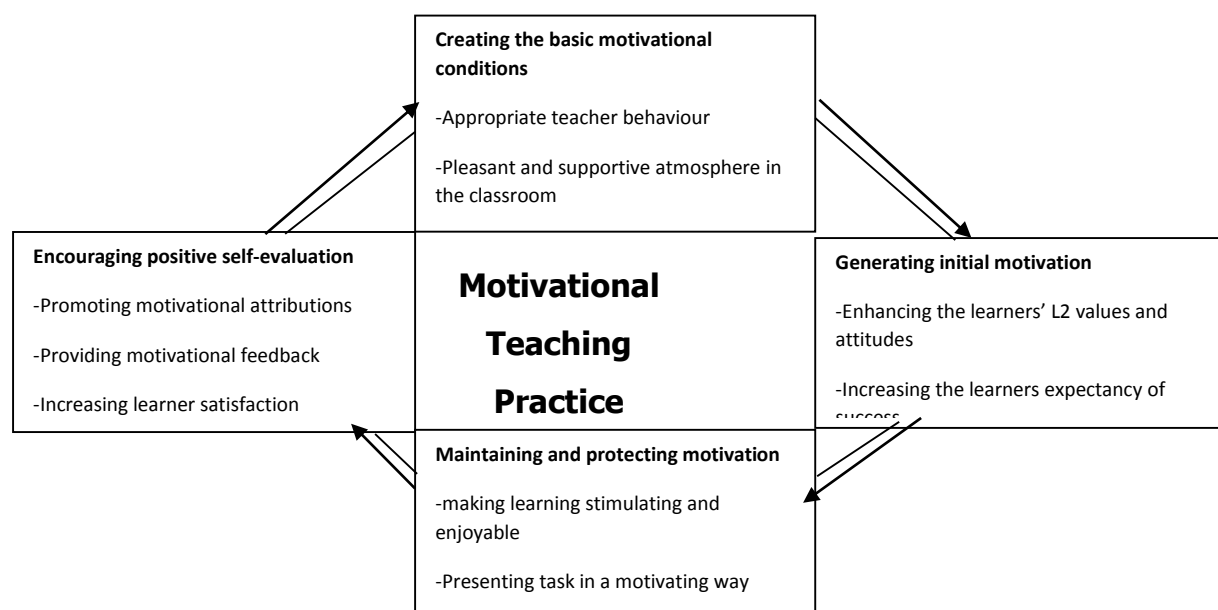
In the South African educational context, families give full weight to English learning language. The desire for better education is often associated with English language learning, and often this results in the belief that sending children at very young age to English medium schools will be advantageous for them. Being exposed to these schools at very young age, South African learners have developed negative attitudes of learning languages like isiXhosa and they hold these attitudes in all aspects of their educational development (De Klerk, 2002:8).

This study anticipates that the history of the isiXhosa language, including other **language communities' contact with isiXhosa speaking communities, may have a role in shaping medical learners' attitudes.** Therefore, as the advantages of positive attitudes are widely accepted and confirmed, the teachers and educational policy makers could develop ways in order to change negative attitudes into positive ones. The sociolinguistic influence of the English language has not disappeared after the breakdown of the British Empire, and is instead growing wider every day languages. Attitudes towards isiXhosa have certain bearings on its history either at individual or societal levels.

Motivation and attitudes

Dörnyei's (1999) motivational framework provides a coherent overview of factors which impact on the second language learning.

Figure 5 Dörnyei Motivational Framework



Svara (2009) writes that motivation has three components, namely, effort or motivational intensity, the desire to learn the language, and attitudes towards learning the language. These features considered together identify a motivated learner. In other words, someone will be considered motivated learner **"if he or she wants to learn the language, regards learning a language as a joyful experience, and tries very hard to acquire the language"** (Svara, 2009:26). Gardner states that motivation is **"the extent to which an individual works or strives to learn the language because of a desire to do so and the satisfaction experienced in this activity"** (Gardner, 1985:10). Dörnyei (1999:6) expands this notion and stresses that learners who are merely confronted with second language within a classroom context will rather identify with cultural values that are attached to the target language than with actual target language community itself. Therefore motivation is not seen as a stable entity but as dynamic factor that increases and decreases throughout the learning process.

Research in the field of motivation to learn second a language has been conducted for **at least the last forty years**. **"Motivation has been accepted by both teachers and researchers as one of the key factors that influence the rate and success of second language learning"** (Dornyei, 1998:117). In addition, it is ascribed to being even more influential than language aptitude which refers to ability to learn the language. Since motivation and achievement in the second language are so closely linked, a learner needs to be motivated in order to do well in learning a second language. The roles and functions of the target language will also influence the motivation towards it. Saville-Troike (2006:86) claims that individual motivation is another factor that is used to explain why some second language learners are more successful than others. The level of effort that learners expend at various stages in their second language development depends on how motivated they are to learn. Gardner (1985:2) states that **"Second Language Learning is a social psychological phenomenon, and it is important to consider carefully the conditions under which it takes place"**.

Motivation is an important issue in (Krashen's, 1982) acquisition-learning hypothesis which claims that adults acquire language just as children do. This hypothesis claims **that the ability to 'pick-up' languages does not disappear at puberty; however, this** does not mean that adults will always be able to achieve mother tongue levels in a second language, as most children can do. This is because motivation is crucial if adults are to achieve second language acquisition and learning goals.

Motivation in second language learning constitutes one of the most fully researched areas of individual differences. The bulk of the research however has focused rather narrowly on integrative and instrumental motivation, relying almost exclusively on self-report questionnaires. Gardner (1985: 50) highlights that **"motivation involves** four aspects, a goal, effortful behaviour, a desire to attain the goal and favourable attitudes toward the activity in question". He further (1985:50) states that:

"The type of motivation which explains why individual is studying the language, which refers to the goal could be listed as: to be able to speak with members of that language community, to get a job, to improve one's education, to be

able to travel, to please one's parents, to satisfy a language requirement, to gain social power".

Instrumental and integrative motivation both seems important in second language learning and acquisition. In the case of medical students, instrumental motivation would be suitable. Medical students need the isiXhosa language to consult with patients and to graduate. isiXhosa is useful for students because it helps them to become better doctors, and is even useful in getting them jobs in isiXhosa communities. Integrative motivation is also important, because it will help students to **understand the thinking and behaviour of isiXhosa patients. "Motivation is extremely important for second language learning, and it is crucial to understand what our students' motivations are" (Oxford, 1994:12). Motivation seems like a good indicator of students' achievement in a second language. According to Oxford and Shearin (1994), it is important to examine the instrumental and integrative motivation among students and to look at its influence on their language achievement.**

In order for the learning of a second language to be successful, the learner, himself who according to Wilkins (1978:51) is probably the largest variable of all in the learning situation, ought to be willing or should want to learn. Wilkins (1978:53) goes on to say, **"research has shown that where learners have rigid and authoritarian views, not surprisingly they are less successful in language learning"**.

Kanjira (2008:23, cited in Gardner, 1985:51) says that it is possible to classify the reasons for second language learning so that they reflect some ultimate goals. An **instrumental goal emphasizes "the practical value and advantages of learning a new language."** The integrative goal stresses an emotional involvement with other communities, whereas an instrumental goal does not necessarily do this. In supporting this, Brown (1987:115) and Ellis (1986:300) also highlight that **instrumental motivation is said to occur when the learner's goal is functional, and integrative motivation occurs when the learner wishes to identify with the culture of the second language group.** Young (1987:87) gives an "example of instrumental motivation when he reports that many South African and African students have a strong instrumental

motivation in learning a language". Education is seen as the passport to a salaried post. Examination success is vital.

The issue of motivation and successful acquisition of isiXhosa in South Africa is complex. There are a few factors that influence the low level of proficiency, especially at universities. One factor is how the course is structured. In the first three years it will be difficult for students to be motivated due to pressure in other learning areas. This will make students prioritise their subjects and they will see language learning as something they can postpone until later years when they are ready to go to the field. It can therefore it will be difficult to motivate and get total commitment from the students. As Alatis *et al* (1981:113) indicates, **"the process of learning a second language is one that involves a total commitment from the learner"**. It looks like without this commitment or interest **"commonly known as inner drive, impulse, emotion or desire that moves to a particular action on the part of learning second language, it will be a futile exercise to teach a second language"** (Kanjira, 2008:22). Gardner (1985:133) says that **students learning a second language "must be both able and willing to adopt various aspects of behaviour, including verbal behaviour, which characterise members of the other linguistic-cultural group"**. This involves both cognitive and affective components, and emphasizing that cognitive factors such as language aptitude and intelligence as well as affective factors such as attitudes and motivation are undoubtedly implicated in second language acquisition.

In the context of medical students learning isiXhosa as language of communication when they consult with isiXhosa patients, motivation can be seen as an instrumental goal. The students learn isiXhosa and Afrikaans for instrumental reasons, such as better communication between them and isiXhosa and Afrikaans speakers, to understand better the culture of isiXhosa patients and above all to be better doctors. There is also an element of integrative motivation, since the learners have to go and visit hospitals that are in isiXhosa dominated communities.

Ellis (1994:513) also states that:

"Integrative motivation has been shown to be strongly related to second language achievement. It combines with instrumental motivation to serve as a powerful

predictor of success in formal contexts. Learners with integrative motivation are more active in class and are less likely to drop out. However, integrative is not always the **main motivational factor in second language learning**".

On the other hand, scientific research has demonstrated that attitude biases thought to be absent **or extinguished remain as 'mental residue' in most students (Mckenzie, 2006)**. Studies show people can be consciously committed to equality, and deliberately work to behave without prejudice, and yet still possess hidden negative prejudices or stereotypes (Joy, 1987). He shows a link between hidden attitude biases and actual behaviour. In other words, hidden attitude biases can reveal themselves in action, especially when a person's efforts to control behaviour consciously flags under distraction or competitiveness (Joy, 1987). Unconscious beliefs and attitudes have been found to be associated with language and certain behaviours such as eye contact, blinking rates and smiles (Mckenzie, 2006). If people are aware of their hidden biases, they can monitor and attempt to improve hidden attitudes before they are expressed through behaviour. This behaviour can include attention to language, body language and to the stigmatization felt by target groups (Mckenzie, 2006). Common sense and research evidence also suggest that a change in behaviour can modify beliefs and attitudes (Mckenzie, 2006). It would seem logical that a conscious decision to be equal might lead one to widen one's circle of friends and acknowledgement of other groups (Mckenzie, 2006). Such efforts may, over time, reduce the strength of unconscious attitude biases (Mckenzie, 2006).

Attitudinal studies in the world in have not reached a consensus yet, as societies in different contexts attribute a mixture of feelings to languages.

However, the researchers tend to share some common points on the major factors which can be summarised as follows:

- (a) Integrative motivation has proven to enhance second language acquisition (Shaw, 1983).
- (b) Instrumental motivation has also proven to increase achievement in the language acquisition (Shaw 1983).

Instrumental motivation along with integrative motivation could be claimed to have the best effect (Cooper and Fishman, 1977)

2.4. The Importance of language communication skills in a medical career

Bakic-Miric (2008) wrote that patient-doctor communication is the building block upon which the doctor-patient relationship is made. She describes that very often patient's expectations go beyond clinical competence because on the whole patients expect doctors to be "respectful, polite, sincere, compassionate, and interested, with appropriate demeanour, with proper verbal and non-verbal skills, that is, all traits that make up a doctor's personal signature" (2008:74). Evidence suggests that a 'patient-centred approach' to communication in the clinical consultation improves health outcomes, reduces costs and leads to higher patient satisfaction (Hashim, 2012) and language skills play a pivotal role in the whole process. The principles of the patient-doctor relationship have to be applied to practical situations, for instance in clinical interviews. Doctors need to influence their patients to become or remain supporters of good self-care. In order to do this, doctors need to establish three key conditions in their communication with patients: shared values, shared language, and mutual respect Stone *et al* (1998).

Today's patients vary considerably in their desire to participate in clinical decision making, but they all have particular expertise or voice, for example like using the patient's story as the starting place, listening for the patient's meanings as he tell the story to bring to the medical table (Stone *et al* 1998). According to Stone *et al* (1998:17), there are two types of patients, the patients who prefer little or no involvement in the clinical dialogue and the second kind are patients who prefer to be actively involved in their clinical dialogue. The first kind of patients tend to be older, sicker, and more satisfied with traditional medical care, have learned to view the doctor as the expert who prescribes the treatment plan with which they will comply as they are able or willing. Other patients who fall into this category include those from cultures in which it is considered disrespectful to ask questions or raise concerns with an authority figure such as a doctor. Such patients will be reluctant to express their concerns, and will need encouragement to bring their voice about their own lives into the discussion. The doctor may need to use their role as an authority figure to

invite these patients to help them, with statements such as the following: "I will do my job better if you tell me what things might prevent you from following this **treatment plan**".

The second type of patients, are patients who prefer to be actively involved in making decisions about their health care and medical treatment. These patients, who generally are younger and better educated, or who may have been actively self-managing a chronic illness for some years, tend to be less satisfied with their medical care.

Importance of language and culture in medical context.

It has long been recognised that difficulties in the effective delivery of health care can arise from problems in communication between patient and health provider. As the result of these difficulties **the nurse is often expected to assume multiple roles, "those of a linguist, cultural broker, counsellor, patient advocate and institutional gate keeper" (SAMJ, 2009:3). Good communication can have beneficial effects on health outcomes (Bakic-Miric, 2006).** Bakic-Miric mentions that for a successful and satisfying **visit at the doctors' office, the doctor needs to be sure that the patients' key concerns are addressed. The doctor can only do this by understanding the patient's perspective on his or her illness.**

According to Bakic-Miric , patient values and cultures need to be respected, including their language, gender race and education. Respecting patients means listening to their information, whether it is accurate and useful, or misleading or wrong. Therefore doctors need to listen carefully and put information from patients into the context of their patients. In doing so, the doctor is letting the patient know that he or she respects them and value their information.

Gender and race are also elements that need to be taken into consideration in consultations (Bakic-Miric, 2006). According to Bakic-Miric, (2006:78) **"modern medical technology is not a replacement for professional patient-doctor relationship"**. Bakic-Miric also states that both verbal and nonverbal skills play crucial role in face to

face consultation, and create trust, understanding and a successful rapport between the two partners.

Cultural distance between doctor and patient reduces trust and understanding, compromising the quality of care given. The role of culture in medical care is related to the 'Health Belief Model' which defines cultural barriers to care as "primarily internal subjective beliefs" (D'Avanzo, 1992:246). Cultural differences often translate into cultural barriers that lower access to health care. Again, according to Pillay (1993:1), there is a "strong evidence supporting the view that beliefs and attitudes influence health behaviour" and that "cultural and social beliefs have been shown to influence the way health care is used". Pillay (1993) emphasises that although western medicine plays a dominant role in health care of black communities, the black communities still possess "unique attitudes, values and beliefs about health and illness which integrally influence their health behaviour" (1993:ii). The people still have personal conceptions of illness, health and disease that influence their manner of help seeking.

Schuman's behaviour model is one model that is 'related to some individuals' behaviour' regarding illness. The individual tries to understand or attach meaning to the symptoms with the belief that a Western doctor might not understand a certain kind of illness, especially those associated with use of magic spells and folk illnesses, i.e. illnesses that are commonly recognised within a cultural group and whose explanatory models often conflict with that of the Western paradigm. Cultural preferences for using traditional treatments can also be associated with cultural history. Many culturally different patients turn to traditional treatments first, and then to Western medicine, or employ traditional treatments in conjunction with Western medicine.

It is thus very important that any doctor practising among black South African communities has an understanding **of the people's culture. In order to do that they** need to understand the cultural beliefs of the community they work in and the language of the community. However, proficiency in language does not necessarily bring with it cultural familiarity and competence. They may still lack cultural knowledge

of patients, including values, beliefs, and traditional illnesses. Overcoming a language barrier is a major step in effective communication, but cultural differences can still affect the patient-doctor relationship.

Doctor-Patient Communication and Health Outcomes

According to Stewart (1995:9) “effective communication between doctor and patient is a central clinical function that cannot be delegated”. This section will discuss the importance of doctor-patient communication for the health outcomes of patients.

“Patients must be able to trust doctors with their lives and health. To justify that trust the doctor must show respect for another human and he or she must work in partnership with patients and respond to their concerns and preferences, give patients the information they want or need in a way they can understand, and respect patients’ rights to reach decisions with you about their treatment and care (General Medical Council, 2009).

The principles of a patient-doctor relationship have to be used in practical situations, **for example in clinical interviews. The doctor’s purpose in the clinical interview is to gather “diagnostic information, to offer expert knowledge, and to make decisions in the patient’s best interest” (Lumma-Sellenthin, 2013:8).** It would facilitate an easy interview if the consultation could be communicated in a language that the patient and doctor both understand, with clear communication to the patient, so that they feel understood. In elaborating further this point, Levin (2005:9), who is a doctor at **the Red Cross Children’s Hospital, said that doctors and patients do not always** understand each other. Sometimes names of common illnesses can mean something different to the patient than to the doctor. This is because English disease names may be used differently by patients and doctors and may be used to refer to culture–**specific models of disease. Results of Levin’s 2005 study at Red Cross Hospital showed** that parents of children were dissatisfied with communication, citing problems with understanding the doctor, and being unable to make themselves understood or to ask questions. The consultation style demanded by ethical principles of the General Medical Council mentioned above assumes the **doctor’s willingness to share** information with the patient and to acknowledge the patient as an equal partner in

consultation. Thus the principle of teaching language skills to medical students arises, in order to increase communication skills with patients, using contents of consultations as examples.

According to Makoul, the doctor-patient framework should include these elements:

- building the doctor–patient relationship e.g. greetings and personal history
- Opening questions e.g. what is wrong today?
- Gathering information e.g. asking how and when questions
- **Understanding the patient's perspective**
- Sharing information
- Reaching agreement on problems and plans
- Providing closure (Makoul, 2001).

From the above points, communicative skills have been shaped that will suit all medical practitioners and these include:

- **Eliciting the patient's main problems and perceptions as well as the physical, emotional and social impact of the patient's problems on his life situation.**
- Tailoring information to the **patient's needs and checking their understanding** (Stewart *et al*, 1995).

Courses in communication skills instruction aim at teaching precisely some of these skills. Previously, it was commonly thought that doctor-patient communication was generally adequate and was not cause for concern (Lumma-Sellenthin, 2013). However, there are many problems that arise from language barriers, gender, education and race. These result in problems of diagnosis and lack of patient involvement in the consultation process. It is where perceptions of disrespect or unfair treatment within the doctor-patient relationship are common. Such negative perceptions influence health care use and may contribute to the existing health inequality (Bakic-Miric, 2008). The Medical Research Council is beginning to highlight how health care encounters might relate to inequality in use of services and quality care (Lumma-Sellenthin, 2013). For example, language barriers between the doctor and the patients is associated with little satisfaction and no participation in

consultations. For example, the indigenous South African patients who have black doctors are likely to have more patient satisfaction and greater participation in decision-making (Bakic-Miric, 2008). Chalabian and Dunnington, (2006:89) support **this view by saying it is believed that “patients whose doctors do not speak the same language are more likely to omit medication, miss doctor’s appointment which result in these patients not having regular doctors”.**

When patient-centred approaches are adapted to particular clinical contexts, different aspects of communication may be emphasized (Hudon, 2012). However, discrepancies between academic standards and medical practice are common, and in practice, the use of patient-centred communication can be restricted by many factors such as time constraints and economic or personal factors. Introducing language communication skills courses in the medical curriculum at UCT was an opportunity for improving doctor-patient relationships and understanding of patients as human beings. Communication and interaction are core elements of the relationship between the doctor and the patient. Hence, this is a course that helps students improve their clinical skills, their ability to relate to patients, and communicate with understanding. It helps them to understand the importance of listening to patients and to understand that a good doctor-patient relationship is crucial for successful treatment.

2.5. Designing a manual for Second language learning and teaching

My understanding of a manual is that it is a practical guide for the classroom teacher and students. In other words, a manual describes procedures and offers sample exercises and activities for a wide range of listening, speaking, reading and writing skills for different purposes in a classroom situation (Peace Corps, 1989). Therefore, a teacher designing a manual for second language student needs to learn about the **students’ needs and attitudes towards learning the target language.**

This is important so that from the beginning they can design exercises that will satisfy the needs of the students.

However, different approaches work for different students. Larsen-Freeman (1986:1-2) says that **“there is no single accepted way to go about teaching language today”.** Thus, the teacher’s task in designing a manual is to identify and use different teaching

approaches to suit different students, while learning to trust their teaching instincts of when to switch techniques. With all this in mind, the goals for the course must not be forgotten, and techniques need to be used to teach students skills to achieve the goals.

Of all four key language skills, speaking is deemed to be the most important in learning a second language (Khamkhien, 2006). In any language learning, speaking is a critical part of language learning. Hence, a manual must make speaking it a focal point.

As a manual designer, it is important to address the whole person, by using the Communicative Approach (Littlewood, 1983). This involves prioritising interactive activities in the manual, such as participation, interaction, encouraging competency, building confidence and developing communication strategies.

a) Participation

Students are more likely to participate in a language lesson if they complete activities which involve them. Another motivation for participation is to make activities in the manual fun. In doing so, however, make sure that the students are covering the goals of the course and the teacher is serious about their intentions to help the students succeed in learning the language.

b) Interaction

The manual can be stimulating if there are exercises that give students the opportunity to talk to each other with little assistance. Interactive activities in the manual encourage students to communicate. However there are some obstacles related to implementing interactive activities. The most commonly cited obstacles to interactive speaking are: restriction of the classroom, limited practice time and learner anxiety (Peace Corps, 1989). The manual designer needs to strive to create lessons which allow all students to feel relaxed, and exercises which allow easy transition between whole class, group, and pair work. The teacher and students also require space to move around the classrooms for activities such as role plays.

c) Encouraging Competency

In the Communicative Approach (Littlewood, 1983), communicative competency can take priority over accuracy. Essentially, the manual needs to encourage speaking competency, in order for language speaking to flow. There may be mistakes, fillers, repetitions, and pauses, as long as there is speaking interest in the manual activities. The students will not always be accurate in their use of the language, but this is not as important as understanding (Klippel, 1984).

d) Building Confidence

A common comment from students learning a second language is that they dislike **making 'a fool' of themselves (Peace Corps, 1989).** Students can feel foolish when they are not in control, and may be reduced to a needy dependence. Thus the manual needs to aim to reduce fear and build up confidence and pleasure in practicing the language.

e) Developing Communication strategies

The manual need to develop two major communication strategies: accessibility and managing a conversation. Accessibility refers to students being able to use the manual on their own when they need to. Managing a conversation is encouraged by practicing communication strategies in conversations or activities, and these should be woven **throughout the lessons. The designers' task** will be to make the students aware of the strategies and of how to use them, and help them use these strategies when speaking the language.

6. Conclusion

This section has described a number of theories on second language learning and teaching pedagogies in the classroom. I have drawn from readings which dealt openly with second language learning and teaching pedagogies in the second language classroom. The study did not only look at the application of current social theory to language teaching, but looked for suggestions of the possibilities for meaningful links between languages and cultures in second language teaching.

It also looked at ways of making teaching better in the classroom. The intensity of the effort required to teach isiXhosa to medical school students has created its own problems. One major problem is the shortage of isiXhosa second language teachers and another is the lack of expertise in isiXhosa language pedagogy of many teachers.

While South Africa has produced strong policies to guide African language teaching and teacher development programs (Alexander, 2002), I know from my own experience that teachers are still not well trained in current methods and pedagogies of Second language teaching.

Pludderman *et al* (1998) state that teaching directly from text-books and learning by rote is the norm, especially in schools. Students are often indifferent and not motivated to learn, and as a result lack interest and commitment to learning and acquiring these languages (Bilash, 2009), despite the fact that isiXhosa is one of the keys to career advancement of medical students. Pufahl *et al* (2000:4) write that “language and education policies at the national, regional, and local levels can either facilitate or inhibit strong second language education”. In the classroom, second language learning is enhanced by the creation of opportunities for participation, scaffolding and **motivation in which students’ involvement needs to take centre stage.**

Overall, the emphasis should be on teachers’ awareness of second language pedagogy; making language learning meaningful, valuable and relevant to students. The theories discussed also suggest that second language teachers need to have access to more pedagogical strategies by being able to research and creatively develop different skills for second language teaching in the classroom. Hence it is very important that teachers give students a solid foundation in learning basics, because this is where everything starts. If students lack language foundation skills, they will have continuous problems with learning and this will lead to rote learning. Trying to lay down the foundation to tackle these early on could help students in the near future in their second language learning and acquisition journey.

Chapter Three: Methodology

Introduction

This section will firstly broadly examine research methodologies used in this field, and then secondly describe the specific methodologies employed in this thesis.

Methodology theory

3.1. Direct Method

A direct approach to the investigation of attitudes usually involves questioning subjects on their beliefs, feelings and knowledge of the attitudinal objects. The Direct Method **when measuring language attitudes is often based on the participant's responses to questions and interviews.** In the direct method, participants have to respond to the questionnaire. Questionnaires are designed to look for their opinions or beliefs about the language they are acquiring. Some of the ways used in this method have features of qualitative methods, such as open-ended questionnaires and open-ended interviews. The Direct Method also has features of quantitative methods such as close-ended questionnaire responses that are quantified and analysed numerically. **According to McKenzie (2010:42), "the direct approach by its very nature has a greater degree of obtrusiveness because the participants themselves are expected to give an account of their attitudes".**

Henderson *et al* (1987: 22-24) divide these methods into research instruments that call for written responses and those that call for oral responses such as surveys and polls. The questions may be prepared but the interviewer has the freedom to pursue interesting responses if required. A survey refers to highly structured interviews that do not necessarily take place face to face. Questionnaires are most often employed when the researcher requires answers to a variety of questions.

McKenzie (2006) describes an attitude scale as a specific type of questionnaire designed to ensure that the number of several answers results in a single score, which represents one overall attitude. One advantage of the attitude scale is that it ensures

consistency because unreliable items can be left out. Unreliable items are those items which produce responses which **are inconsistent with the informant's answers to other** items. However, according to McKenzie, the measurement of language attitudes by direct methods is subject to a number of potential pitfalls which researchers should be aware of, regardless of whether word-of-mouth or written response procedures are employed. A number of these relate to factors which language attitude researchers bear in mind in the preparation of interview schedules.

Issues such as 'social desirability' need to be taken into account in the employment of a direct approach to language attitude measurement. Stoeber (2001:222-232) explains social desirability in more details:

Social desirability bias is a social science term that describes the tendency of the review respondents to answer questions in a manner that will be viewed favourably by others. It can take the form of over-reporting "good behaviour" or under-reporting "bad", or undesirable behaviour. The tendency poses a serious problem with conducting research with self-reports, especially questionnaires. This bias interferes with the interpretation of average tendencies as well as individual differences.

This raises issues regarding the validity of the data collected. Oppenheim (1992: 139) maintains that "social desirability bias is often of greater significance in interviews than questionnaires". Respondents may describe their language behaviour in a way that makes them appear more decent and socially respectable than they actually are, or indeed in a way that makes them appear as they think the researcher would like them to appear, a well-known phenomenon described by Baker (1992:19) as the "halo effect". **However, conducting interviews individually** and guaranteeing confidentiality and anonymity with subjects is likely to reduce the risk of social desirability bias.

Indirect Method

The Indirect Method of attitude measurement is generally considered to be able to penetrate deeper than direct methods, often below the level of conscious awareness **and or behind the individual's social cover up. The Indirect method of research, such** as document analysis and observation, explore phenomena from the outside. This **approach can be particularly useful in** "bringing to mind a memory of feelings and

outlining stereotypes and exploring unconscious situations such as ideas connected with learning or teaching” (Oppenheim, 1992:210).

Mixed Methods

Today we can find an increased number of studies which demonstrate various possibilities to combine methods aspects into articulate research designs. As Brennan (2008) notes that mixed methods research strategy offers different opportunities for social science researchers. Firstly, it provides researchers with a good context for skill enhancement in methodology; secondly, it encourages researchers to think flexibly, and ‘outside the box’; thirdly, it informs the public policy and practice and offers the appropriate frame and language to communicate with policy makers; fourthly, it allows for large-scale cross national research and culturally contextualized research to be included in the same study; and finally, mixed methods research allows for the use of language distribution.

Mixed methods research is defined by Tashakkori and Teddlie (2008:82) as “a combination of at least one qualitative and one quantitative component in a single research design, aiming to include the benefits of each method by combining them”.

Tashakkori and Creswell (2007) created a forum for sharing ideas and discussing important issues in mixed methods research. The quality of mixed methods research is directly dependent on the purpose on which the mixed approach is chosen in a particular study. Seven reasons for conducting a mixed methods research have been listed by Tashakkori and Teddlie, (2008: 21-30) as:

Complementarity: to address different but complementary aspects of an investigation; to get different perspectives about the same experience.

Completeness: to be certain that a complete picture of the experience is obtained.

Developmental: questions from one type of research emerge from the inferences of a previous one; or one strategy provides a hypothesis to be tested in the second one.

Expansion: to expand the understanding obtained by one strategy.

Confirmation: to assess the credibility of conclusions obtained from one approach.

Compensation: to compensate the weaknesses of one approach by using the other.

Diversity: to obtain divergent pictures of the same experience; the quantitative and qualitative findings can be compared and contrasted.

Mixed methods strategy is consistent with the principle of triangulation, in which the **combination of “two or more methods are used to gain added-value and to produce more valid results than would be obtained by using only one research strategy”** (Denzin & Lincoln, 2000). Patton (2001:247) advocates the “use of triangulation by stating that it strengthens a study by combining methods”. This means using several kinds of methods or data gathering processes, namely, qualitative and quantitative approaches. This study will employ survey questionnaires as a quantitative measure and interviews and observations as qualitative methods, aiding to provide confirmation and completeness in the research investigation. The use of triangulation will allow the study to capture a more complete, holistic view and reveal the varied dimensions of a given problem, with each contributing an additional piece to the puzzle. It can also minimize bias and validity can be enhanced (Patton, 2001: 247).

Qualitative research

Qualitative research is the most common approach in educational research about processes of teaching and learning, classroom relationships and how students learn. For example, Tang (2002) used both quantitative and qualitative methods in conducting classroom observations, interviews and questionnaires in his exploration of the use of Chinese in English language teaching at the university in Beijing. In this method the researcher becomes the instrument of data collection, and results may vary greatly depending upon who conducts the research Bryman (1988) mentions some important distinctions between different research methods. The qualitative approach that I have used therefore combines several methods to collect data, namely students, teachers and observations. The aim was to uncover the complexities of **learning a new language. Miles and Huberman (1994:10) states that “qualitative data provide thick descriptions that are vivid, nested in real context, and have a ring of truth that has strong impact on the reader”.**

Kervin et al. (2006:37) writes that qualitative research can be seen as “an approach to making sense of situation happening in a natural setting where the researcher is not interested in objective measures but preferring to explore the subjective experiences, ideas and feelings of the participants.” Bryman (1998) states that the most important aspect of qualitative research is to see through the eyes of those being studied and translate actions from their point of view. Aziakpono (2009:43) also states that “a major weakness of this approach is that it is not very easy to determine the extent to which the researcher can actually present accurate accounts of participants’ point of view”. This observation highlights the fallibility of qualitative research methods, where gaps could exist between subjects’ utterances and the interpreter or researchers’ understanding.

Examples of qualitative research are individual case studies and ethnographic studies, participant observation, individual interviews and focus group discussions. In social sciences, “qualitative research can be conducted through the means of both direct and indirect method. These methods are used in order to explore a phenomenon from the point of view of the subjects of the research” as Aziakpono (2007:38) mentions.

Quantitative research

Kervin et al. describe quantitative research as considered to be the more “scientific” approach (2006:34). The focus is on using specific definitions and careful meaning of particular concepts and what the variables occurring in the study mean. However, Kervin et al. (2006:35) explain that there has been a shift away from quantitative methodology towards qualitative methodology in educational research:

Educational research was initially dominated by quantitative research designs because this was believed to be a superior form of gaining knowledge. Dissatisfaction with quantitative approaches arose in the latter part of the twentieth century because the kinds of questions that were relevant in education settings were not adequately answered by quantitative means. As a result, in recent years, there has been an increase in qualitative studies that allow insight into these complex educational issues.

In the quantitative approach, observations about human behaviours are described and analysed numerically and statistically (Jackson, 1995). Examples of quantitative

research as identified by Bryman (1988) include surveys, experimental studies, structured observations and content analysis. Quantitative research data are usually regarded as more reliable because of the systematic methods employed in collecting data. Quantitative methods, such as surveys and polls focus on gathering an extensive amount of data.

Challenges

There are plenty of challenges that can be experienced with data collection and contradictions in certain areas and results are likely. For example in interviews, challenges lie with difficulties in organising the data, since the responses are open and varied. In **observations, the presence of the researcher might affect the subjects'** comfort, and thus interfere with their behaviour, and possibly results of the study. There are also issues that might come into surface during analysis. Whereas quantitative research data is usually regarded as more reliable because of the systematic methods used in collecting data, quantitative research is usually more representative than qualitative research and findings often formed an opinion about the participants at large (Kervin et al., 2006). The disadvantage of surveys lie in the nature of the questions used. The subjects may report what they want the researcher to hear or what they believe the researcher would like to hear.

3.2. Current research methods

Aim:

The aim of this study is broadly to investigate the problems faced and attitudes towards the isiXhosa Communication Skills Course in the Health Sciences Faculty.

Objectives:

In the Faculty of Health Sciences, isiXhosa is taught specifically to equip students with the necessary skills to improve their communication with patients.

The first objective of this research is thus to find out what the problems with teaching and learning in the isiXhosa Communications Skills Courses are, in the Health Sciences faculty.

The second objective of the study is to look at the second language pedagogy used by teachers teaching isiXhosa classes.

The third objective is to investigate attitudes and perceptions that the UCT medical students held in learning isiXhosa.

Research questions

What are the problems in the isiXhosa Communication Skills Course in the Health Science Faculty? Specifically,

- (a) Why are students not acquiring enough competence in isiXhosa to be able to communicate with their patients?
- (b) To what extent is teaching and learning impacted by second language pedagogy?
- (c) What are language attitudes of students studying isiXhosa Communication Skills?

Ethics:

Since this study involved observing and interviewing human subjects, ethical approval for this study was sought and obtained from the Faculty of Health Sciences Human Research Ethics Committee.

Before the research started, I had already identified staff that I could work with in the medical faculty. These were people that I knew from teaching languages in the medical school. When I communicated with them about the research, they were **interested since the study was investigating students' attitudes to doing languages in medical school especial isiXhosa**. Therefore, they saw the study as an opportunity to get insights into the course since my research questionnaire which they had seen, covers some aspects of teaching and learning and a small part of assessment.

Questionnaire: 63 questionnaires were distributed. The individual interviews involved 12 participants. I conducted four classroom observations.

Methods:

The teaching of isiXhosa as a language for professional-specific purposes in UCT is a course characterised by varying institutional and pedagogical complexities. The problems and complexities in the course are therefore best understood through the experiences of participants through questionnaires and interviews. *Several methods* were thus used in this research in order to obtain the desired data to answer the

research question. These were: self-evaluation questionnaires, semi-structured interviews, classroom observations and an evaluation of the manual used by the teachers in the communication skills course. *The questions asked in the questionnaire are valuable in giving a general picture of how students feel about learning isiXhosa as a second language. The questions asked in the interviews, on the other hand, seek opinions and beliefs of students learning isiXhosa.*

1. Self-evaluation questionnaires

In order to investigate learning second language, the attitude toward the learning and use of isiXhosa as a profession-specific language, a self-evaluation questionnaire was conducted.

The scale that was used was the Communication Skills Attitude Scale, created for **measuring medical student's attitudes towards** learning communication skills,(Rees, C., Sheard, C. and Davies, S. (2002).The development of a scale to measure medical students' attitudes towards communication skills learning: the Communication Skills Attitude Scale (CSAS).

(Lumma-Sellenthin, 2013) was selected as the data collection tool. The questionnaire **used in this survey is divided into two parts, referred to as "factual questions, and questions about subjective experiences"** Frankfort-Nachmias and Nachmias (1996:251). Factual questions are asked to obtain background information about participants. They are used to classify participants or are analysed as variables that may influence attitudes. On the other hand subjective experiences are often in the form of belief statements. These questions deal with participants' **beliefs, attitudes, feelings and opinions** (Frankfort-Nachmias and Nachmias, 1996:251). Aziakpono (2007:46) **suggests that these "questions or statements arouse participants' attitudes for or against an issue, and help to reveal whether the participants have favourable or negative attitudes toward an object such as language"**. A careful analysis of the data can provide many useful insights into the participants' attitudes.

Part one of my survey was thus to establish background information of the subjects, such as gender, age, previous education, marital status and first language. It consisted

of seven questions. Part two aimed to discover attitudes towards the course. It consisted of 20 questions and was divided into three sections: The importance of language and culture in medical context; Teaching and learning in the isiXhosa course; and assessment.

The questionnaire contained 27 statements/questions that respondents were asked to rate on a four-item scale (see Appendix A), of: (i) Strongly agree; (ii) Agree; (iii) Disagree; and (iv) Strongly disagree. **The reason for excluding a fifth 'neutral' option was motivated by the desire to prevent respondents from resorting to that option in order to avoid difficult questions.**

Questionnaire administration

Once the proposal had been cleared by the Health Sciences Ethics Committee, formal permission was obtained from the head of Primary Health Programme of the medical school and tutors before conducting the survey in the classrooms. All the data was collected **in the students' regular assigned classroom, most frequently after a** customary scheduled class. The procedure involved in each class visit was standardised. For example, prior to each class visit, contact was made a day in advance with the tutor. After a small introduction by the class teacher, I personally administered questionnaires to students in classrooms after lecturers. Confidentiality was assured, since the questionnaire was anonymous. 63 questionnaires were distributed. I had a 100% return since the questionnaires were filled in my presence. It was believed that diversity of the participants recruited in the study was crucial to make the sample representative of the target group as a whole.

3.2.1. Semi-structured Interviews

The survey questionnaire was followed by recorded semi-structured interviews. Semi-structured interviews were chosen because of the structure and flexibility involved in this form of data gathering. Although they are guided by a schedule containing interview questions, "the researcher is allowed to re-adjust the questions or ask other questions which are not in the schedule in order to clarify or elaborate on certain points to gain more information", as suggested by Frankfort-Nachmias and Nachmias

(1996:234). The informants were given the freedom to express their views on a topic, despite the fact that it is a structured interview that is guided by prepared questions. In order for the interviewer to obtain detailed information to meet the purpose of the study, probing was used to encourage the respondents to give reasons for any views they hold.

The semi-structured interview process is used to explore specific questions as well as open ended questions. I had prepared interview questions before hand, but allowed the students to stray from the question at times to follow-up the question to allow the natural flow of the conversation between myself and student as long as it was relevant. I also probed when necessary to get more details or explanations. Through the individual interviews, I hoped to be able to probe individual attitudes and perceptions more deeply. I hoped that through the individual interviews, I would allow the participants to air their own personal opinions and attitudes without the obstruction from others. I chose not to conduct focus interviews in order to avoid students influencing each other.

Administration of interviews:

The procedure for interviews was the same as for questionnaires. I spoke to the head of the MBCHB isiXhosa programme for medical school who informed tutors teaching isiXhosa at medical school about my research. The head arranged for me to have a meeting with the students before requesting candidates for interviews so she could introduce me to their class and request other tutors to do the same and give me access to their students. Prior to the interviews, I met with the students and explained to them what their involvement in my study entailed and that the information they were to share with me would be kept confidential and would be used only for the study purposes. I also explained to them that they could withdraw at any time during data collection. All the participants agreed to participate in the study. The individual interviews involved 12 participants. An interview schedule containing nine open-ended questions was used (see Appendix B).

The participants were randomly selected from those that had shown their willingness to participate and were representative of all students in factors like age and gender. I asked them to choose the location where they would want interviews to be done in **an “informal relaxed atmosphere” as Frankfort-Nachmias & Nachmias (1996:240)** suggest. All of them preferred their rooms and small classrooms in medical school since most of the interviews were conducted on Friday afternoons. The interview took approximately 30-45 minutes and students were given incentives for their time.

All the interviews were recorded with a small tape recorder placed in a relatively unobtrusive position. The students did not appear to be intimidated by the tape. The real names of the respondents were kept anonymous and codes were used to identify each interviewee. Each student was informed that s/he could withdraw at any point during the interview. I also explained to the students that participation was optional.

3.2.2. Classroom observation

While analysing the questionnaire data, which helped me highlight key issues, I realised I needed to explore further. In particular, I needed to shift away from a narrow focus on language attitudes to a broader focus on other issues such as second language acquisition and second language pedagogy. This can be examined through classroom observations.

For my observations, I chose to use the relatively less-structured observation. The reason for this attributed to Gall and Borg (1993) who said that the origins of the less-structured method lie in the anthropology tradition which aimed to explore the social meanings that underpin behaviour in natural social settings. Gall and Borg (1993) continue to say that there are numerous approaches to observational research. They explain the difference between more structured observation and less-structured. They say the two approaches originate in different academic traditions, and have different aims, purposes and procedures. I use a degree of structure through use of an observation checklist alongside my hand written notes. I designed my checklist based partly on previous research, my research questions and on understanding issues of second language pedagogy.

For the observation, I looked at the ways in which second language is taught, i.e. how and to what extent they use participation in their teaching, their pedagogical styles and to what extent the students seemed to be engaged in language learning. Overall, the observation assessed the effectiveness of each lesson to produce the required outcome, which I believe is the ability to teach language learning and acquisition. Good language learning and acquisition will be the predictor in how ready they are for communicating with patients. Therefore I used my checklist as a guide of noting the gaps and strengths of each style, and the notes I took allowed me to identify the **teachers' shortfall in the classroom. I also noted how teachers and students relate to each other before the actual teaching happened.** I conducted four classroom observations.

The table below gives the observation checklist.

Table 2: Key areas of observation with pedagogy checklist

Students' attitudes
Class time
Lesson : clear learning and language objectives
Materials
Collaborative activities planned for purposeful talk
Learning scaffolded using L2 methods
Opportunities to use L2
Students' behaviour
Appropriate grouping of learners
Evidence of learner progress in lesson

Data analysis:

Descriptive statistics served as the method of analysing the quantitative data. The qualitative data was analysed by using the questionnaire, interviews, observations and the manual as guides to identify themes that arose in the data.

This research used triangulation **as its theoretical perspective, aiming at student's** attitudes, teaching and learning. It is a qualitative research study, dealing with individuals own accounts of their attitudes, motivations, and learning experiences. The selected number of participants inevitably cannot represent the whole medical **students' population learning isiXhosa. However, the findings of the study may** legitimately be expected to contribute to knowledge about isiXhosa language learners in the UCT Medical Faculty.

Chapter Four: Data Analysis and Discussions

Data analysis and Discussions

In the section, I will present data and analyse it drawing on the data that was collected. My data is based on questionnaires that were administered to students, observations of classroom teaching and interviews with learners. In addition I have looked the manual that was used in the classes.

The following is an analysis and discussion of the survey questionnaire. The questionnaire can be found in Appendix A.

4.1. Background interpretation of the survey questionnaire

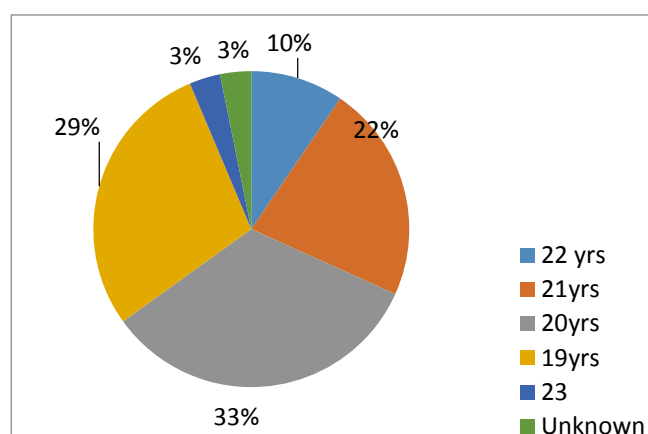
A total of 63 second year medical students completed the Communication Skills Attitude Scale (Rees, Sheard, & Davies, 2002). The questionnaire was used to assess **individual student's attitudes towards learning isiXhosa Communication Skills Course**. The CSAS consisted of 27 questions using four point scale, from strongly agree, agree to strongly disagree and disagree. The Statistical Package for Social Sciences was used for data analysis. The percentages will be presented in the form of tables and charts. As shown in Table 1, the sample consisted of more females (34) than males (29). The average of age of the sample population is between 19-22 years.

Table 1: The distribution of students according to different variables

Age	number	Percentage
19-20	39	62%
21-22	22	35%
23 & unknown	2	3%
Gender		
Male	29	46%
Female	34	54%
Languages		
Monolingual	9	13%
Bilingual	29	44%

Multilingual	25	38%
Schooling Type		
MOD C	32	51%
DET	7	12%
HOR	5	7%
HOD	4	5%
Non-South Africans	12	20%
Unknown	3	5%

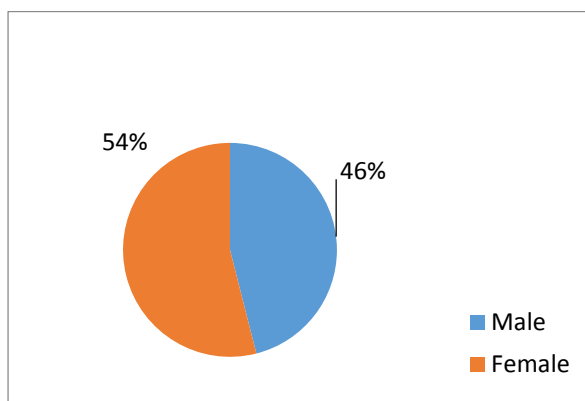
Figure 1: Age Category of respondents



As indicated in Figure 1 above, 29% of the respondents were 19 years old, 22% respondents are 21 yrs old. 33% respondents are 20yrs old. 10% respondents are 22 years old. 3% are 23 yrs old, while another 3% is unknown. The students are adults and they need special needs and requirements as learners. Also adult learners are goal driven in language learning. When looking back at theory about age, Brown, (2001:60) mentions that children and adults learning a second language tend to acquire that language differently. Children acquire new language subconsciously and naturally when it is delivered to them. Children often acquire the new language inductively and effortlessly, unlike adult second language learners. Adults tend to focus on parts of the language trying to comprehend how the new language works and how it is different from their mother tongue. They often tend to analyse language forms.

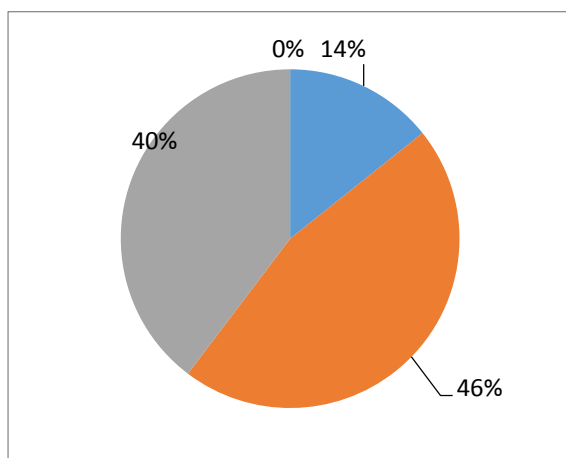
This, however, may impact negatively on their speed of language acquisition and, because of this, the adult learner tends to take more time to move away from focusing on forms of language to the purposes of the language. Hence it is important to nurture **the learners' because in early stages of learning a language, adult** students are fragile and need support from their teachers. This is the time the teacher needs to exercise patience and empathy to maximise the development of their new language.

Figure 2: Gender



The female participants in the survey comprised 54% of the total research population, while male participants comprised 45%.

Figure 3: Language subjects speak

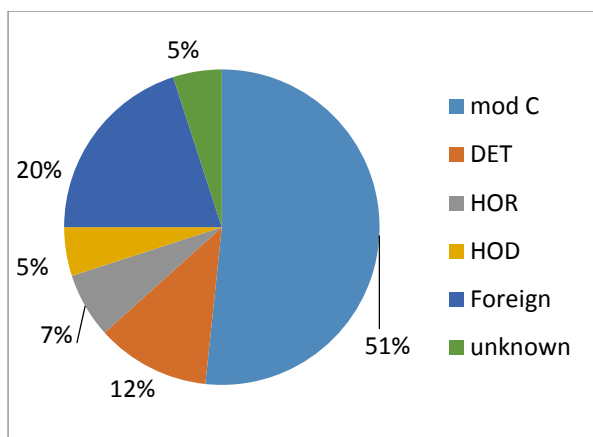


A total of 46% of the respondents considered themselves bilingual, which for the majority of them was English and their mother tongue. 40% of students considered themselves multilingual, which means they could speak more than two languages. Students who considered themselves to be monolingual totalled 14% of the research population, and because English is the university medium of instruction, it is safe to assume that it is English. When combining bilingual and multilingual percentages, one can see that majority of students are exposed to more than one language, which can be Afrikaans and English, English and isiXhosa and another language.

Schooling

The students came from different schooling backgrounds. Figure 4 shows the schooling background of the students. English is being taught as the medium of instruction in most of these schools, except the former Department of Education and Training (DET) schools. Former Model C Schools were previously under the control of **the House of Assembly during the apartheid era and are usually 'white schools'**. Students from Model C schools constitute the largest group of students (51%). Model C schools were and still are the schools that have the best facilities, best teachers and best educational opportunities for children, followed by schools for non-South African students at (20%). Students from the former DET schools constituted 12%. DET schools are usually schools with little or no facilities which are mostly situated in townships, informal settlements and rural areas. The former House of Representatives **(HOR) was the department that handled coloured children's schooling and 7% of the** survey group come from the HOR. Former HOR schools, although they were not quite as sidelined as DET schools, still have really poor infrastructure and facilities. House of Delegates (HOD) schools had been reserved for Indian pupils before 1994. Students from HOD constituted 5% of the survey population.

Figure 4:



Language Statements

This section will look at two statements that were used in the survey to test students thinking in relation to language learning, and statements which are used to test language attitudes.

Statement 1: More should be done to promote indigenous languages in university.

The vast majority of students agreed that indigenous languages like isiXhosa should be promoted at university. According to the percentages, 79% of females support language promotion at university followed by 72% males. There is 28% of male and 15% of females who do not support promotion of indigenous languages in the university. There is also 6% of students who did not respond to the statement. So far, all indications point to a positive attitude of learning languages by the participants. This was validated by the vast majority agreeing with the statement, 'more should be done to promote indigenous languages in university'.

Statement 7: Learning a language in tertiary institutions should be a voluntary thing.

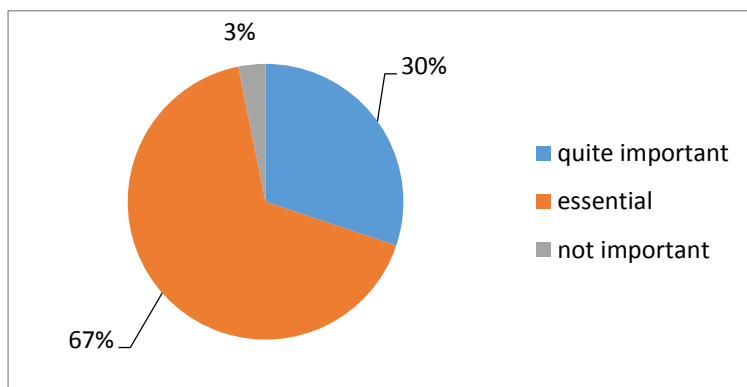
The majority of students, 19% strongly agreed and 48% agreed that 'learning a language in tertiary institutions should be voluntary', and not compulsory as is the case in the current medical curriculum. 30% and 3% strongly disagreed or disagreed

with the statement. This statement is also vital in this study because it shows indications of students' feelings about isiXhosa language course.

The following statements below are designed to probe students' thinking regarding the importance of language in communication with patients.

A considerable proportion of students agreed that 'language communication is essential or quite important in communicating with patients'. (Question 22 – see Figure 5)

Figure 5: Importance of doctor-patient communication



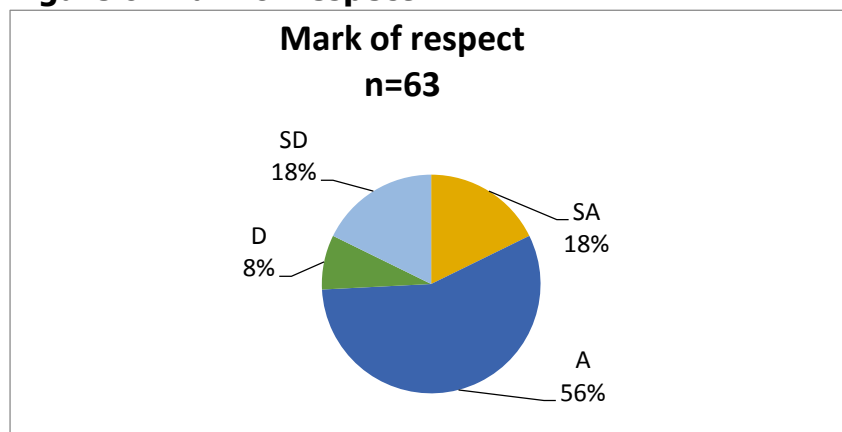
Statement 5: It may be an advantage to my career to be able to communicate in another language

The majority of students (67%) acknowledged that isiXhosa is essential in their future careers. 30% of students believed that isiXhosa is quite important in their future careers. The importance of language communication skills within the medical context is supported by their percentages, while only a minority of 3% think that is not important.

Statement 3: It is a mark of respect to people to learn their language if you are providing them with health care.

18% strongly agree and 56% agree with the statement that 'it is a mark of respect to understand your patient's language'. In contrast, 18% of the students in this group strongly disagree with the statement.

Figure 6: Mark of respect

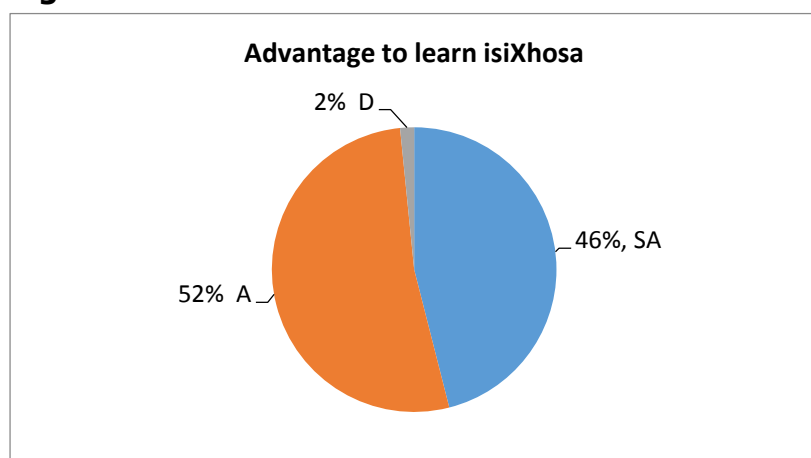


Statement 4: It is important to understand peoples' culture and value systems before providing them with healthcare.

Students support the view that culture needs to be respected as one will see the students' responds. As D'Avanzo (1992) states that cultural differences often translates into cultural barriers that lower access to health care. Hence it is important that any doctor practising medicine in South African communities have a little understanding of the people's culture.

Statement 5: It may be an advantage to my career to communicate in another language

Figure 7



'It may be an advantage to my career to be able to communicate in another language' illustrates that the 46% of the participants are in strong agreement with the statement

and 52% of participants agree with the statement. The percentages support that they agree that another language will be an advantage to their future career, which will be isiXhosa and Afrikaans in the Western Cape. Only 2% disagree with the statement. If we are looking at Baric-Miric (2008) where they describe doctor-patient communication as a building block upon which the doctor-patient relationship is made. In clinical consultation the doctor needs a language to communicate with his/her patients. Therefore, the percentages here are supporting the instrumental value and need for motivation of isiXhosa teaching and learning in medical context. Students seem to agree that they need isiXhosa language because it will make them better doctors.

Statement 9: The isiXhosa communication skills course has been effective in making me more communicatively competent in the isiXhosa language.

Responses to this statement indicate that the majority of the participants agree with the statement. According to the graph, 66% of participants indicate that learning isiXhosa has helped them to gain competency in speaking the language. The fact that they claim competency shows that they are interested in learning to speak the language. On the other hand, 34% percent of the participants disagree with this statement. It is also apparent that the students are struggling with speaking isiXhosa because 34% disagree with the statement.

Summary of Findings

In the survey, I did not find a significant difference between positive and negative attitudes towards the isiXhosa Communication Skills course. Instead, students were more positive in their responses whereas in their observations and interviews I sensed more negative than positive attitudes. Although the majority of students responded positively, there were a few negative statements that were written by students especially when given the chance to explain. For example, regarding the statement 'language communication is essential or quite important in communicating with patients', one student wrote, "nobody is going to fail their medical degree because they can't speak a language". Other students wrote "I can't see the point in learning if I cannot speak it," and "we are under pressure with other subjects so it's difficult to

pay attention to languages". With statements like these it is apparent that there are still students who do not value the course.

Assessing the survey, students seem to appreciate the opportunity to learn isiXhosa and have early contact with patients through language. They see this contact as having importance for their professional development. They agreed that a good doctor-patient relationship is an important part of the consultation. This agreement is in line with theory. **Bakic-Miric (2008) said that "doctor-patient communication is the signature of clinical consultation". I believe that the students are aware that good** interpersonal relationships, established by appropriate communication skills, are of the same importance as the clinical knowledge. Though positive attitudes dominate this survey, negative attitudes should not be overlooked because surveys can be deceiving when it comes to attitudes.

Regarding the promotion of languages at university, the majority of participants agreed that more should be done to promote languages at university. This is an immensely important statement coming from the students, because they agreed regardless of their ethnic and linguistic backgrounds and this is the vital fact for the university language policy makers to increase their effort in promoting languages.

The majority of students consider learning a language as a mark of respect. Most students disagree that culture and values are not significant when it comes to medical doctors. This signifies that all students understand that the cultural background of the patient is important if you are practising medicine. This is discussed extensively in the literature chapter of this thesis. The more they understand the culture of their patients the better.

After looking at personal accounts of how each respondent perceives isiXhosa and what attitudes they had towards isiXhosa especially in their career advantage, one can say that medical students clearly emphasise the importance of isiXhosa language regarding their career success. This indicates further that these students have a strong realisation of the instrumental role of knowing isiXhosa in their careers. Even though

majority of respondents responded positively in response to this statement, 2% did not seem to agree. Since it is a small percentage, one must consider the fact that there are foreign respondents among the groups.

If the majority of students agree with the importance of language in the medical context, and yet they are not motivated to speak, then there is disconnection. Either the course is not doing what they expect or the teachers are not ensuring that the course fulfils its objective. Another reason could be related to other factors like their previous schooling experiences which did not prepare them for their current studies. The last reason for their negative attitudes may be the result of offering the course early in their medical career because the students have less experience of communicating with patients at this level.

The purpose of the statement 'learning a language should be voluntary at tertiary level' was to test the validity of the previous statements that involve language learning at tertiary level, and the theory that argues that the bottom-up approach in language learning work better than the top-down approach. The theory argues that people tend to resist when a language is forced on them as opposed to when they volunteer to learn it. That is why as a teachers need to make language attractive and accessible and 'cool' enough so that students come on their own. To force students to learn a language is likely to backfire and have the opposite results to what is intended .*Forcing students to learn a language may result in them resisting the language, rather than being willing to learn it (Moon, 2000).*

Looking at the percentages of participants who agreed with the statement shows that some students are not ready to learn languages. The majority of students identified themselves as happy with language learning at university and as wishing to see it being offered to all students not to only those who wish to learn languages. The results for this statement tell a different story. What this indicates is that the students are still not ready for the languages, regardless of its social importance because of various reasons which originate from attitudes. The numbers also highlight that as long as people are presented with linguistic choices, African languages will simply not be on

par with higher status languages. The fact that even those who identified themselves as African did not think of their language as important might be attributed to one possible factor, namely their language and culture have been viewed in a negative light.

4.2 Classroom Observation

In this section, I present data resulting from four classroom observations of isiXhosa lessons taught by four bilingual teachers who are all based in the Department of African Languages at the University of Cape Town. I will begin by giving a little background information about the teachers, and then give an analysis of the lesson in each classroom and comment on each lesson. At the end, I will give a summary of my findings.

The duration of the observation was ninety minutes for each of the four classes. One of the interesting aspects was watching the interactions between teachers who had varying teaching styles, and students at different levels of second language proficiency. All the teachers taught from a manual. This handbook was designed by teachers themselves as a class manual. Three of the teachers taught the same lesson. The classes were slightly different from one another and the degree of participation with students differed between these classes. The teachers will be named A, B, C and D respectively, to avoid using their names. As I mentioned earlier, the checklist was used to observe the teaching pedagogy and teaching styles of each teacher and how they differed from one another. It also enabled me to observe how each teacher used the manual which is an available resource, and whether this was supplemented with other language teaching materials.

I will start with a description of the classroom observation for each teacher and then I will critique the key features and comment on the key features of the lesson, the atmosphere and dynamics of each classroom, the content of the lesson, and the teaching style of each teacher.

Observation A

Teacher A graduated from the University of the Western Cape and she majored in languages. She has been teaching in the university for a year. The class consisted of students who were doing the second year of their MBChB programme (term three). These students had already completed a section on language introduction in term two. Term three is the continuation of term two. The class was held on the medical campus in although the language programme is offered by Humanities. The class started at 10h30.

There were 13 students in this classroom. There were 8 females and 5 males. This group of students was made up of mostly students for whom isiXhosa was a second or third language. Although they are South African students who might have heard **isiXhosa language, but they don't understand it. There were also international** students: 2 Mauritians and a Zimbabwean were also part of this group and these students had never heard isiXhosa before. The class started a few minutes late because of a last minute change of venue which the lecturer complained had been happening regularly. I am mentioning this point because I felt it tells me about the challenges teachers are faced with. The lecture theatre had all the teaching facilities like a whiteboard, overhead projector and power point tools. Since it is a lecture theatre, the students were sitting in rows and the lecturer was standing in front of the classroom. The classroom setting is significant in teaching a second language because the teacher should be in contact with his or her students all the time to assist.

In all the classes, I selected an unobtrusive position that would allow me a clear view of all students and the teacher by sitting at the back of the class. I usually sat so that **I could have a better view of students' faces and actions but remained uninvolved.** In all the classes I took notes. I wondered if the students would make an extra effort in their learning because I was in the classroom.

The classroom atmosphere and students' behaviour are good indicators of how students feel about learning. Looking at student movements and body language as they came into the class, I observed no excitement. They did not greet and did not

attempt to speak some isiXhosa as I usually witnessed in my classes when students were coming in. There seemed to be no interpersonal relationship between teacher A and her students. The teacher and the students did not attempt to engage in any informal oral conversation. The teacher and students were both using a compiled booklet.

The content of the lesson was about HIV symptoms. The dialogue and symptoms were in the booklet. The teacher started the class by telling the students which page to turn to in the booklet. The teacher started going through the dialogue which was between a doctor and a patient. The students were listening and writing the translation of the dialogue. The teacher was doing all the talking, and translating the dialogue for the students. The dialogue was in isiXhosa and the teacher was translating into English. The whole booklet seemed to have difficult language construction for second language students. Here is an example of a statement taken from the lesson:

Mama esi sifo sibangelwa zintsholongwane ezifumaneka kwincindi zesini sobufazi okanye sobudoda (This sickness is usually caused by HIV virus which is transmitted through bodily fluids exchanged during sexual intercourse).

I would describe this as a fairly difficult construction and students will have difficulty comprehending it. The language is difficult for the students, because it is proper and formal isiXhosa register. I thought that these students still needed input of a fairly basic level first. The vocabulary used in this particular lesson was not simple. The grammar and syntax the teacher was using was too sophisticated for the students at this level. Bilash (2009) advised that the best way to teach and to get students attention is to build on what students already know. That is why it is important to structure the lesson into small steps to teach the new vocabulary in a way that it is an extension of what students already know. As one would anticipate, in this type of classroom it is difficult to create group work because of sitting arrangements. The students who were involved fully are those who are sitting in the front row. Many students, especially those sitting at the back rows, were less involved. One student was making sketches while two were eating snacks while the lecturer was teaching.

The register was signed at the end of the lesson. The register thus encouraged attendance but not participation.

Critique and Comments of the lesson

As I mentioned earlier, the language and the method of teaching was advanced for the level of these students; if it was complex for first language speakers it must have been more so for second language speakers who had only just started the isiXhosa class a year ago. It was thus not surprising that the students were not participating. Firstly, the arrangement in this class was difficult for the teacher to move around. She had to stand in front of the class all the time. Secondly, the teacher was not really involving students in the lesson which makes difficult for her to keep track of everyone in the classroom. Thirdly, her teaching technique could have been different, for example, she could have started with vocabulary drills to familiarise the students with pronunciations, then word meaning and later give examples of vocabulary usage in context. Vocabulary is perhaps the most basic component of second language learning and without a variety of terms and phrases students cannot communicate in the target language. Therefore, the teacher needed to introduce new words and phrases in manageable chunks. The teacher should do that in a way which involves the provision of context and examples. But in this class, there was little use of this strategy. I am aware that I have not been observing other classes therefore, I can only speak with certainty about those classes I observed.

The construction of the example in the previous section could have been simplified to a level which second language students could cope with. The statement could have been broken into simpler register. By doing so, the teacher would have been creating a simpler way of constructing sentences, without using compound questions and then checking for learning or understanding by asking a series of simple questions, each focusing on a single aspect of the concept or vocabulary to be learned, For example, it could have been broken down into:

- *Mama esi sisifo esibangelwa yiHIV virus (This is a disease that is caused by the HIV virus)*

- *Ifumaneka kwincindi yabafazi namadoda (It is carried by male and female sexual bodily fluids.)*
- *Uyifumana xa ulele nomfazi okanye indoda (You get it when you have sexual intercourse)*
- *Isuleleka xa ungazikhuseli (it is transmitted when you are not using protection)*

The questions could be as follows:

- *Isifo seHIV sibangwa yintoni? (What causes this disease?)*
- *Sifumaneka phi? (Where is this disease found?)*
- *Sifumaneka njani? (How do you get this disease?)*
- *Sifumaneka xa kutheni? (Why do you get this disease?)*

As discussed in the literature review, scaffolding is the “teachers’ primary goal and intention is to assist student to negotiate difficult tasks” (Cameron,2001:9). In this lesson there was no attempt to scaffold and there was no interaction between the teacher and students, except in cases where students needed extra clarity. Students did not get any opportunity to participate in the lesson. The features of scaffolding as they were discussed in Chapter 2 were minimal in this lesson. There was no attempt to provide scaffolding strategies such as those suggested by Cameron (2001):

- **creating students’ interest in the task,**
- simplifying the task, for example breaking it down into stages
- keeping students on track by reminding them of the goal,
- pointing out key things to do and showing students other ways of doing parts of the task,
- **controlling the student’s frustration during the task and demonstrating an idealised way of doing the task.**

As Cameron points out in the list above, these are features of teaching which provide a context for scaffolding to take place, “in a way that combines secure, familiar, non-threatening and predictable vocabulary with space for development, growth, creativity and change of attitudes” (Cameron, 2001:10). The lesson does not contain any of the features described by Cameron that allow space for active learning and creativity to

take place. Once a teacher has established a routine in class, students will expect it in every lesson, and therefore the teacher could have established a supportive teaching repertoire suited to second language acquisition.

Therefore, scaffolding could begin from what is close to the student's experience and build to what is further from their experience. For example, in the beginning of a new task, scaffolding should be visible by first asking display questions, which are questions to which the students already know the answer. The teacher could have used these **questions to determine if students are able to 'display' their knowledge. In the second** language classroom the teacher should ask learners questions to see if they understand or remember what they were taught. Display questions are an important tool in the classroom, not only for the teacher to be able to check and test learners, but also as a source of listening practice for students. It is important that students get as many opportunities as possible to practice their new and old language skills. These activities should be given while still providing scaffolding so that students have time to properly absorb the information given to them and the opportunity to practise. If the teacher always introduces new vocabulary every day, the learning process can silence students who are less motivated and have negative attitudes towards a language, whereas motivated students will make use of the new vocabulary to practise outside the class. Bilash (2009), states that if students are feeling challenged **'emotionally, psychologically and intellectually', they become non-participants**, for example, emotional level may cause one to feel uncomfortable, unsettled and even perhaps overwhelmed. When the students are emotionally and psychologically challenged, attitudes start to surface. The approach the teacher used did not encourage student cooperative learning. Therefore it is difficult to assess if students are paying attention when there is no student teacher interaction. The students just copied what the teacher wrote on the board with no follow-up exercises to test whether they had understood the lesson. They used the manual for the whole lesson, and their activities were minimal to none.

Observation B

Teacher B was a more experienced teacher than Teacher A and C. Although she has no teaching diploma, she has done a course on second language teaching in her Honours programme. She has been teaching isiXhosa at the university for the 5 years. The class also consisted of term three students and it started at 10h30. It was held in the medical school, which is a lecture theatre not suited to small language classes. It is also not suitable for teaching a second language because as a teacher you have limited movement to interact with all your learners. The lecture theatre had all the teaching facilities like a whiteboard overhead projector and power point tools, which were not used to facilitate interaction.

The group was made up of African students only, which included isiZulu, isiXhosa, seSotho and seTswana speakers with class size of 12 students. The class consisted of 7 females and 5 males. Unlike the previous class, this one started on time. The teacher introduced me to the students. The students here were also using the same booklet. But this class was slightly ahead of the other groups in terms of lessons. On this day when I observed them they were role playing a case study of a patient with leukaemia, which had been given as their homework. The lesson had been taught to them the previous week. The teacher wanted the students to role play the same lesson to check if they understood. The atmosphere in this class was lively, with the teacher talking informally with the students before the class started. The students expressed themselves freely in isiXhosa while the teacher was friendly in isiXhosa.

Critique and Comment of the lesson

The students may have been well prepared because the lesson was taught previously, but they managed the role play because some were fluent in the language and they helped others. Unlike other classes these students were little more comfortable with the language and hence could manage the task at hand. They did the presentation in a cooperative manner by helping each other when one of them was struggling with isiXhosa terms and vocabulary. The students presented in pairs and most interactions were in isiXhosa. During the whole lesson the atmosphere was positive because it seemed that most students were comfortable with the language, even the students

that were not first language isiXhosa speakers appeared relaxed. In the class there was much use of switching from one language to another, which helped them negotiate academic challenges they had with the language. These students were all willing guessers when they were not sure, and the teacher helped them out. Most of them had a strong drive to communicate. Above all, they were trying to take advantage of all practice opportunities without paying attention to their mistakes.

In terms of the topic, the language was fairly complex as well. Students that are second language learners would find the vocabulary very challenging. Group activity was not possible due to the type of classroom structure. The group worked together in pairs. The unequal nature of their participation was determined by the differing levels of language and other expertise between the participants. At the same time, the **teacher's commitment to ensuring that the group achieved a successful language outcome** was critical in sustaining the interaction to its conclusion.

Here are few examples of questions and wording the lesson entailed, to give the reader an illustration of some activities which took place.

Vocabulary

- *Ukugruzuka (to be scratched)*
- *Umhlaza othatha ixesha elide (chronic leukaemia)*

Questions

- *Ixhaphake kubantu abangakanani (What age group is it common in?)*
- *Ingaba ikhona imiphumela yonyango (Are there any side effects of the treatment?)*

Co-operative Task execution was evident in this class. Learners' engagement in the task and learners' behaviour was positive throughout the lesson. The teacher managed to develop the interest of the learners. In this classroom, it was easy to see that the students' intentions were oriented to the future importance of learning the language. The attendance register was signed, in this instance, I did not have to wonder if it only served to enforce attendance, as students were fully engaged.

Regarding the teaching procedure, the teacher was working directly from the manual. Students were asked to do a task, which was a presentation of the previous lesson. Therefore, it was not easy to judge the teaching style and to determine whether the students managed the role play because they were more familiar with isiXhosa. It was clear from the student presentations that these students understood the content of the lesson and its objectives. The class in general was well managed and every student knew what to do. The students also showed respect to the teacher. The teacher managed to initiate activities, like role playing and open discussion. There was no group work but the teacher worked with the whole class. The teacher was constantly promoting co-operation and learning of the task by encouraging students to help one another and offered suggestions regarding how best to do this. I did not hear the teacher evaluating the learners, assuming this was not part of her planned lesson.

Observation C

Teacher C has plenty of experience in teaching isiXhosa at high school to first language learners for 8 years. She has been working at this university for a year. The class was supposed to start at 10h30, but it also started late because of a change of venue. The venue was occupied and the facilitator had to go around looking for a venue, so the class started 20 minutes later than scheduled. According to the lecturer the change of venues happened often and she believed it was because it was the isiXhosa Communication Skills class. The lecturer seemed to be alluding to the lack of respect when it comes to the teaching of isiXhosa at a medical campus. The venue for this class was a small tutorial room at the medical school perfectly suited for second language teaching and learning activities. The venue had a white board marker.

There were 9 students in the class, which was fewer than usual but some may not have been aware of the venue change. Most of the students in this class were Indian, with 5 males and 4 females. In this classroom there were no social chats between students. The teacher did not engage students in chatting that was unrelated to the lesson. This is one of the areas where a teacher can build a relationship with students. The teacher could use that informality to establish a classroom atmosphere that is positive and non-threatening. Bilash (2009) emphasizes that the teacher must ensure

that the classroom atmosphere features a cooperative relationship between the teacher and students, and that is relaxed and informal. A relaxed and informal atmosphere is one means of inducing students to interact more and to enhance learning.

My presence in the class did not seem to bother the students. This looked like a fairly friendly group and they seemed motivated to learn. The teacher started the lesson without revising the previous lessons. What I observed in these classes, was not about **building the students' confidence towards talking or motivating students to talk. It was** about the lesson of the day. The teacher just translated the dialogue in the book and the students did not ask any questions. They copied what she wrote on the board, and there was no participation at all from the learners, not even the use of questions to involve students. She did not provide any alternative explanations of difficult points, or simplify vocabulary for them. She wanted them to translate the dialogue first. The teacher had no way of monitoring student progress during the lesson. After translation there was no clear guidance on follow up work or identifying links with the following session. Maybe the reason for this kind of strategy was to finish all the lessons before the semester. In this class there was no pair work, the students were sitting around the table facing the teacher and the board.

Students appeared to be paying attention by looking at the teacher and following her movements. Much like learning, teaching is a complex process that evolves and becomes easier over time. The teacher was using a translation method of teaching. The students also seemed comfortable with the routine. Here the teacher was not giving the students a chance to use or apply what they learned. There was never any activity planned for purposeful talk. The register was signed.

Critique and Comments of the lesson

The topic for lessons was also about HIV illness. As mentioned previously this is not an easy lesson for this level. Here are some examples of vocabulary that was used in the classroom:

- *Kufuneka uxelele omnye umntu ukuze ufumane unyango (you must disclose so that you can get treatment)*
- *Kufuneka uxelele iqabane lakho (You must tell your partner)*
- *Kungenzeka ukuba woyike kuqala (It is normal to be afraid at first)*
- *Ucinga abantu bazokuthetha kakubi ngawe? (Do you think people will gossip about you?)*
- *Nqanda ukudibana ngegazi (Avoid contact of blood)*
- *Kufuneka ungancansi (You cannot breastfeed)*
- *Unelungelo lokugcina isimo sakho silihlebo (You have a right to keep your HIV status a secret)*
- *Kufuneka ube neqabane elinye (You must have one partner)*
- *Kufuneka ufumane unyango ukuze ungaguli (You must get treatment so that you cannot be sick)*

This was a curriculum topic, therefore students had to learn it. The concept was not new to the students, but the vocabulary was definitely challenging to them. As a teacher, one needs to present new ideas, strategies, concepts and information to learners by building on what they already know in small reasonably sized scaffolded doses. The teacher did not use any strategy to make the students feel at ease with the lesson. This should be where the teacher thinks aloud while demonstrating, reminds students of previously learned knowledge or skills that would help them to complete the task or process contents to be learned.

Looking at the vocabulary in the lesson, it is the kind of vocabulary that would overwhelm students if the teacher has not come up with a motivating way of teaching this lesson. This vocabulary can make student anxious and disinterested because it is difficult for the students to use it. This is why a teacher needs to state the purpose of what is to be learned in a manner that is convincing to the students. The teacher could start by introducing the lesson from the easy part to the difficult part and then to the easy part again. This would help to prevent learners from becoming overwhelmed and frustrated. Sometimes teaching is not about the quantity of work, it is about the quality. As long as the student understands what is important, the quantity does not

really matter. As Bilash (2009:3) argues, **teachers need to know two things, “learners must understand what is important and what they need to know and must use a variety of strategies to help students get it”.**

Therefore, in this lesson the teacher should have started with pronunciation repetitively, checking for understanding. The teacher should provide plenty of examples and show various patterns, by doing this she will be simplifying some **challenging parts of the lesson. At this level, the teacher would be building students’** language skills, so they could develop confidence and positive attitudes towards the language. HIV is related to various other topics that students will be familiar with, or you could start with easy topics that students had already covered, lessons like TB, asthma, or gastro. All these topics are related to HIV, and therefore it would be easy to kick start a lesson by asking the symptoms of these illnesses and building on these topics. These topics have simple vocabulary that can generate lot of questions that can lead to the **HIV topic. As Gardner (1983: 11) points out, “break learning into small chunks, and scaffolding and structuring of activities in order to help students understand or remember the input”.** Once the students develop confidence in asking questions, it is easy to transfer the skill to another situation with simple questions or statements that one can use while building to difficult questions or statements.

In the class, the teacher assesses teaching by asking questions. When hearing what students are able to do, that is when the teacher can decide to move or not to move forward. That is where as teacher one decides that the students need more activities to reinforce the input. If none of this happens in the classroom, the teacher cannot know if the students understood a lesson. This lesson observation showed that the students were overwhelmed by an unfamiliar language. The gap between teacher and the students was reflected in the whole activity.

The teacher did not show any enthusiasm in wanting her students to do better in isiXhosa. Secondly, she did not offer a lesson that one can describe as fun or interesting. The teacher did not make learning easier for these students. For example, she did not give students simple vocabulary and clear objectives before the lesson so

that students could at least have found the lesson less challenging. Therefore, it was difficult to stimulate any participation from the students. At the end of the lesson the teacher did not provide extra oral or written input besides the standard materials. Throughout the lesson, she did not motivate students to talk, unless that was coming in the next lesson.

The students were paying attention to the teacher but I am not sure if they understood what was taught since there was no interaction between the teacher and the student to show their understanding.

Observation D

Teacher D is a university graduate without isiXhosa second language background, but she has the experience of teaching language at university level. She has taught at university for 8 years. The class started at 10h30 in a tutorial room and it was a mixture of white and coloured students, also in third term. The class started on time. There were 14 students in the class, 8 females and 6 males and the tutorial room had a white board. The students were aware of my presence as the observer since I was introduced.

The lesson was in a form of a dialogue and the teacher was trying to engage the students by asking basic information and questions. The students seemed very positive about language learning. Most students were paying attention, although a few were not involved. The students were not lost or frustrated but still I could see that they were operating with limited vocabulary which hindered them from participating fully. Nonetheless, the atmosphere in the class was fairly positive. The students seemed to enjoy and understand the lesson. The teacher seemed to be connecting with the students well.

The teacher put more questions to the students before they went through the dialogue. The topic in this class was also HIV illness. After the revision questions, the teacher started asking questions about HIV. The questions were clear although the students were struggling with basic language. As this was their second term, one

would have expected them to understand the basics covered in term 1. By basic information, I mean question formulation, the how, when, and why questions. This teacher was positive in making students feel at ease by making them laugh through various fun examples. Although her students seemed to like her caring skills, it appeared that some her students were not highly motivated. The manner in which she created a positive atmosphere in the classroom was different from other classes because she was friendly to her students and knew some students names.

As was the case with all the previous observations, there was no group work in this activity. The teacher was randomly asking students and some students volunteered the information. It was easy to see that the students responding were the ones who were not afraid to make mistakes. The majority of the students kept quiet.

Critique and Comments of the lesson

At this was term two, the student should be able to ask basic questions like:

- *Uphethwe yintoni? (What is wrong?).*
- *Iqale nini? (When did it start?)*
- *Kubuhlungu phi? (Where is it sore?)*

These are the simple statements that teachers can build on other difficult lessons like the HIV. Second language teaching literature highlights the fact that students need to build on what they already know (Bilash, 2009). Teachers need to introduce very little new vocabulary in order not to discourage students. That is why it is important to involve them, as Bilash (2009) illustrates, the students might not have the target language skills, but they know something about the topic being dealt with, which is **the case with the HIV topic. Feedback from students is crucial for teachers' decisions** about the next move and this exercise gives the teacher a sense of what vocabulary she should emphasise. Like the previous classes, the teacher did not spend time on pronunciation.

Because this lesson was a typical grammar translation lesson there was little evidence of attempts to teach isiXhosa for communication, even though grammar is also an

important aspect of learning a language. In order for students to have functional knowledge of a language they must have at least some knowledge about grammatical constructs. However, one way of teaching grammar to beginners is to use minimal grammar but show patterns, for example, in isiXhosa the pattern in a dialogue between two people is shown by always starting with a **-u-** which indicates **you** and **-Ndi-** which indicates **-I-**. This is a dialogue pattern of asking questions. Also the grammar must be used in context and not in isolation. It is not wrong to teach grammar in a second language class, but the teacher needs to strike a balance when using grammar, especially in teaching isiXhosa as a production tool, that is, teaching students in the context of the conversation, not grammar in isolation.

The teacher in this class focused more on tense form, giving examples like:

- *Qale (started)*
- *Wenze imithambo/ uzilolongile/ujimile? (Did you do exercises?)*
- *Ubalekile? (Did you run?)*
- *Uhambe ngeenyawo? (Did you walk?)*
- *Usele amanzi, usele ubisi? (Did you drink water/milk?)*
- *Usebenzise ikhondom? (Did you use condom?)*

As one can see, all verbs have something in common they all end with -e. The teacher seemed to focus on that aspect of the lesson rather than making them understand the **importance of lifestyle changes when one has HIV. Secondly, the lessons' aim is conversational**, and not to teach these grammatical constructs, although one can highlight them to know the differences in tenses.

Summary of all observations

In Observation A, the lesson was taught traditionally, that is, the teacher provided all the information, while the students were receivers of the information. I found teacher A to be the least creative in her method of teaching in the classroom. Most of the activities observed revolved around non-communicative learning. I felt little enthusiasm emanating from her teaching and the classroom atmosphere was somewhat dull. Teacher A spoke too much in the classroom and made no attempt to engage the students in language learning tasks. She seemed to lack classroom

management skills. Her lack of pedagogical strategies, like scaffolding and student participation was apparent.

Observation 2 was the closest to a communicative task-based style. The class was the most dynamic of all the lessons. The students seemed to understand the symptoms related to the illness regardless of struggling with some difficult isiXhosa terms for few **symptoms. This class seemed to have a positive impact on students' communication.** The good relationship between the teacher and her students was demonstrated by profitable engagement in the exercise. The profitable engagement between the students and the teacher was successful because this class had the majority of African language speakers, some of whom were isiXhosa speakers. Therefore it was easy for the teacher and the students to understand each other which created a positive atmosphere in this classroom.

For Observation 3, although the students seemed eager to learn, the teacher lacked creativity to engage students and I did not see the teacher cultivating student interest by engaging them in the topic and fulfilling their eagerness to learn.

In Observation 4, the class had a positive atmosphere, but the students seemed to have difficulty speaking, and their motivation was low. I found the teacher focused more on the grammar rather than on communication. Overall, the students were involved throughout the lesson and seemed to follow some parts of the lesson. In all four observations, there was little motivation from teachers, and students showed little interest during the teaching period.

INTERVIEWS

Analysis of Interview data

My research study of language attitudes in medical school needed to include data **regarding students' views and experiences** about the learning and teaching of isiXhosa as a second language at UCT medical school. In this section I present the findings in of the interviews with students. The students spoke about their attitudes to learning isiXhosa, and about the teaching methods **the teachers use. The students' views**

mirrored to a large extent my observations and impressions described in the observation section.

In the beginning of the interviews, I told the participants that I was doing research on attitudes towards teaching of the isiXhosa language at the UCT medical school. The questions in the interview schedule were used as guides for points I wanted to cover. **To determine respondent's attitudes towards isiXhosa, nine questions were asked,** among which were whether they felt learning isiXhosa was helping them to communicate better with isiXhosa patients. See Appendix B for the interview schedule.

In the interviews there was a sense of unanimity about the importance of isiXhosa in their future career, and they felt not knowing isiXhosa was a barrier in their quest to become good doctors. They also made it clear that their classes were minimally interactive, and in their opinions a communicative style of teaching with a variety of activities would be preferred to maintain their interest. **Collectively, the students'** opinions seemed to support the view that there are benefits from learning isiXhosa, but in their experience, there is plenty that could be improved.

Sample - interview participants

The student interview questions focused on language, teaching and attitudes towards the isiXhosa communication skills classes. I interviewed four monolingual students who claimed to speak English only, four bilingual students who spoke English and Afrikaans, and two isiXhosa speaking students who claimed to be multilingual. I also interviewed two non-South African students. In all, I conducted twelve interviews of six females and six males. Each student was interviewed separately and the interview took about 30-45 minutes. I was helped by tutors in the process of selecting students. All the students were comfortable using English and I informed them that the information would be used for research purposes only.

Results

In response to the question: **'To what extent is the lack of proficiency of isiXhosa a barrier in your hospital visits?'**, the following responses were

recorded. Ten of the twelve students said that language is a barrier in their hospital visits. It is a huge barrier in such a manner that the majority of students seemed to avoid consultations with isiXhosa speaking patients. A typical comment was that students never volunteer to assist isiXhosa patients. For instance S1 said:

I prefer to consult English or Afrikaans patients, we share the same language. I am more capable of managing my consultation. I feel at ease consulting them. I understand what their needs are and act accordingly. With isiXhosa patients, I am not in control of things because I need a translator because I do not have sufficient isiXhosa knowledge (S1 bilingual).

Another student referred to the disadvantages of not sharing a common language and cultural background with the patient:

Consulting isiXhosa patients is difficult because I do not share linguistic and cultural backgrounds. I am never sure that I am doing the right thing. If I do not understand a point in the conversation, I would go to a nurse or a Xhosa student and ask for clarification (S4 Monolingual).

Another student referred to the impact on doctor- patient confidentiality:

The language barrier I have with isiXhosa undermines doctor patient confidentiality which is very important in medical context. I become very frustrated because I cannot even create rapport with a patient. I am more worried about making mistakes that can cause harm to the patient. It is also sad for me because I do not really know how these patients feel after a consultation (S5 monolingual).

On the other hand the isiXhosa speaking students seem to prefer isiXhosa speaking patients because language was not a barrier for them. Here are some of their comments:

I prefer to speak with isiXhosa patients because I can relate to what they say and connect with them. You see the relief in their faces when they see a Xhosa speaking doctor. The patients feel free to ask questions (S7 multilingual).

Another isiXhosa student stated:

Like any other student, I prefer to speak with isiXhosa patients when it comes to consultation because they understand me. I can relate to what they say and connect well with them. They feel free to ask questions and I also feel relaxed when doing my examination. I realised the importance of learning a language of your patients, because I am not fluent in Afrikaans sometimes some information needs to be explained in Afrikaans for more understanding, but

now I need to understand Afrikaans little better. In the classes we use English in everything that is why English seems so important, but we work at hospitals as well and not everyone understands English there, therefore we need to learn the other languages as well (S3 multilingual).

Another isiXhosa male respondent said:

isiXhosa is my first language therefore I do not have problems or barriers communicating in isiXhosa. I attend isiXhosa classes and do the work when it is necessary. I still use isiXhosa to communicate with my peers, family and people in my community and I understand the importance of it in training as a doctor. When we go to hospitals I have noticed that when I am consulting with isiXhosa speaking patients they are happy when they see is a black doctor, they will even express some other things (S4 multilingual).

A female respondent who was not a South African, mentioned that not speaking isiXhosa is a barrier to a certain extent, but it does not really affect her consultation. She said that she spoke a bit of isiXhosa because some of her friends are isiXhosa speakers. **Secondly, she said that "she was not intending to practice medicine in South Africa". She said:**

But being a doctor is supposedly to be a calling, you need to like or talk to people regardless of what race. Practicing medicine means you are going to work with people most of your life. Therefore, you should try hard to familiarise yourself with the language of surrounding communities. I find it strange that the South Africans are so negative in learning languages **and yet there's so many languages spoken in this country. I guess as long** as the African languages are restricted to the lower functions here, people will always resist learning them. Also the complexities of attitudes here are shaped by media of the communities that students live in. I stay in Observatory and I never saw a Xhosa newspaper or heard a radio that represents other South African languages other than English. All these influence young people. (S9 multilingual).

A male student who is not a South African was positive about learning isiXhosa. He said he does not view having to learn isiXhosa as barrier but instead it is helping him reach personal ambitions in the medical domain. He said:

In Mauritius, learning a language is always seen as a personal development. I like learning a new language, to me it is not a barrier I see it as a positive challenge. In hospital I like communicating to isiXhosa patients because they are very friendly, you never hear them complaining. (S12 multilingual).

He also said:

Language communication has a very important role in medicine, where you can see people from different races with different languages. In medicine it plays a connecting role between the doctor and the patient. **Personally, I think it's great that UCT is offering isiXhosa because** students can learn more about isiXhosa language and culture. I am able to communicate a little bit with patients. Learning isiXhosa is a must if a student intends to practice medicine in the Western Cape (S12 bilingual).

Studies in South Africa have shown that “many doctors consult across both language and cultural barriers” (South African Medical Journal, 2009:1). However, the majority of health interactions are still mediated by a third person. The impact of the third person, together with linguistic barriers, poses a large obstacle to the medical care in most medical settings. Very often the nurses are put into the role of translator or mediator. As a result of this mediator role in clinical interactions, the nurse is often expected to assume multiple roles, those of a linguist, cultural broker, counsellor, patient advocate and institutional gate keeper.

According SAMJ, (2009: 6) “at the heart of effective diagnosis and treatment lies the medical interaction between doctor and patient”. Although everyone agrees that language communication plays a vital role in the consultation between the doctor and **the patient, the students’ comments indicate that the communication challenges still** occur in doctor-patient interactions especially when there is a difference of language and culture. When these challenges happen in interactions, patients show little interest in the whole process.

Firstly, to reinforce this view, one isiXhosa student, **mentioned that, “you see relief in their faces when they see an isiXhosa doctor and they feel free to ask question.”** This comment seems to support that isiXhosa patients are more satisfied when their provider speaks isiXhosa. Chapter 1 highlights the brief history of languages in South Africa and how language barriers affect doctor-patient communication. For example, Levin (2005) writes that there is a noticeable gap in health service attendance and

status between isiXhosa speaking persons and English and Afrikaans individuals in health services.

Crawford, (1999:29) highlights another issue that language barriers might cause **between doctor and patient**. She argues that **"there seem to be power relations operating within health system as a whole. It is not strange to observe that the patient is excluded from the whole biomedical discourse. This makes the patient occupy a disempowered position"**. Crawford continues to argue that **"doctors are located at the top of the hierarchy as the 'eye' that probes the patient's body, while the patients are positioned at the bottom, largely passive bodies whose own version or narrative of their illness is not accessible to their doctors."** According to Crawford, language barriers create unbalanced power dynamics in the doctor-patient relationship. This statement reinforces that the doctor-patient relationship also suffers in the process of communication. **It is supported by the students that "patients whose doctors do not speak the same language are more likely to omit medication and miss doctor's appointments which result in these patients not having regular doctors"**.

Thirdly, because of these language barriers, these patients face several additional barriers to care like spending more time in hospital waiting areas. For example, one of the students mentioned that because the majority of students avoid consultation **with isiXhosa patients, "intake processes and appointments result in long waiting times for their appointments"** (S3). This student's comment suggests language as a barrier is resulting in long delays for these patients to see doctors which can be interpreted by these patients as poor standard of care and doctors do not care about them.

The students emphasised that during medical consultations with the patients, the **doctor's ability and willingness to communicate across language barriers and to understand socio-cultural variations in health beliefs, values and behaviours** are critical to the delivery of satisfying health care. In the context of learning languages, language and culture are intertwined. You cannot really separate one from the other. A few cultural concerns were raised by students in these interviews regarding doctor-patient interaction. One student was concerned about her handling an isiXhosa adult male.

She said that she is not sure if she handles the patient appropriately due to socio-cultural differences between patient and doctor:

As a white female student sometimes I am not aware of the sensitivity that comes with handling isiXhosa patients. Some of us do not pay attention to the parts considered sensitive and that **they should be avoided, instead we follow a book forgetting about putting the patients' feelings** first. I have notice that some isiXhosa patients are very conservative how I do and say things will be different in their context, so one could easily offend a patient not knowing just because one lacks cultural awareness (S7 monolingual).

Another student felt that she does not understand some cultural aspects. The student emphasised that during **medical consultation with patients, the doctor's ability and** willingness to communicate across language barriers and to understand socio-cultural variations in health beliefs, values and behaviours are critical to the delivery of satisfying health care. Learning any language is primarily about learning how to use it correctly and appropriately according to native norms. Language cannot be taught without the knowledge of the target culture, which is why second language learners need to have knowledge of the cultural and social background, as well as the behavioural styles of the members of the target culture.

In response to the question, '**Do you understand enough about the patient's illness/pain problem?**', the majority admitted that if it were not for the help of the nurses and their fellow isiXhosa students, they would never understand enough about **patients' illnesses or problems. Here are some comments which the students made** regarding this question:

We assume sometimes that they understand us and they are trying hard to seem as though **they understand us, and agree when you ask 'do you understand?'** When it comes to the actual testing the knowledge of what you told her/him, you find that she did not understand at all. They hear something but they understand **something else. Yet you can't keep asking them if** they understand, because it becomes uncomfortable (S2 bilingual).

Another student said,

Sometimes you suspect this and a patient tells you another thing, for example you want ask if they have asthma and you know the word for asthma in isiXhosa is *isifuba*, but in their response a lot comes out, and you cannot really get it (S4 bilingual).

From these comments, there seems to be a great deal of frustration involved in communication between the student doctors and nurses. The students feel that there are long conversations happening between nurses and patients that they are missing out on. They felt that the nurses gave them a reductive summary and nurses exert more authority than doctors.

Secondly from what one of the students said there also seemed to be tensions between the learners and nurses who are helping them. Patients have expectations when they come to hospital. One of the expectations is that the doctor will tell them what is wrong with them, explain to them what they must do to get better but with the little communication between doctor and patient, patients feel cheated.

In response to the question, **'Did you enjoy the isiXhosa course?'**, Very few students actually mentioned that they enjoyed the course. The majority of students (9), said that they felt it was a waste of time because they still cannot communicate with isiXhosa patients. They also stated that the course was difficult and boring. One isiXhosa student felt that there is not a balance between medical information and how **to practice medical services in isiXhosa**. **"Although it is not a problem for me, since I can speak isiXhosa but I sympathise with other isiXhosa second language learners"**. One of the isiXhosa students said that she thought it would be beneficial if the material which they used, though medically based, could emphasize communicative skills in isiXhosa. She identified several needs that were common to students. She suggested **that 'the material needs to be interesting, topical and useful'**. She emphasised that the tutors do not need to worry about getting medical terms right in isiXhosa because they are not experts, they need to teach students how to communicate.

Recommendations from students:

The following are some of the areas which students suggested the tutors focus on in the courses:

- **"The major skill is to have conversational ability in isiXhosa"**
- **"familiarity with isiXhosa, way of asking questions"**
- **"practise isiXhosa medical vocabulary"**
- **"general health vocabulary"**

- “anatomy”, and
- “do lots of presentations”.
- They said that “the purpose of these classes should teach students to communicate with patients, rather than learning a language”.

One can agree with the students with regard to teaching language for specific purposes. Basturkmen (2006) supports the views of students who want to learn the language for communicating with patients. As he has indicated (cf. Chapter 2.5.1) second language learners often need to acquire the colloquial language of the community as they wish to enter and understand the culture and the language of consultation.

The next question was: ‘Are you satisfied with the way the course is taught?’

Overwhelmingly, there seemed to be a great deal of negativity with teachers and lack of satisfaction with how the course was taught. Most of the students said they did the course because they had no choice in the matter. The following student comment indicates that students felt they did not achieve much in the course:

As a student you learn because you want to **understand the course, but if at the end there’s nothing to show for it, you feel like you’ve wasted time. You did it all for nothing because you still can’t communicate with patients (S10, bilingual).**

Students also mentioned the fact that they did not receive much practice in the class, which the observation also highlighted. The teachers explained and translated almost everything into isiXhosa without involving students. The teachers did not provide opportunities for students to use isiXhosa, nor did they give them much exposure to spoken isiXhosa. As confirmed by the interviews, the lessons were more teacher-centred and students had no opportunities to work in groups or to practice, which for students seemed to hold more interest. The first matter that Basturkmen (2006:25) **considers as a necessary factor in the development of such a course is “deciding whether a course should be narrow or broad”.** By narrow, Basturkmen refers to teaching basic language skills in reference to a particular discipline or occupation. A broad course refers to teaching broad skills, and teaching of common needs with reference to a set of disciplines or occupations. She claims that the course designers are also faced with the fact that groups consist of learners with different levels of proficiency and needs. An example of such a group is the group of medical students

doing isiXhosa where there are first, second and even third language isiXhosa learners. The question arises whether a consideration would be to constitute the groups according to isiXhosa proficiency. In the interviews, the students mentioned that they should be divided; the isiXhosa first language learners were especially vocal about this issue because of the nature of the language and their advanced proficiency compared to second and third language students.

Teaching in such a course should be centred on the subject specific language use that is familiar to the students and patients. Teaching should also aim to show how language is used in everyday environments. Secondly, the teaching should stress the importance of developing target performance competencies at least in a medical **context or basic conversational skills. Basturkmen (2006) states that 'competency-based occupational education' is an approach that focuses on developing a learner's** ability to perform required activities expected by a specific profession and function to the standards that are expected by a specific profession and line of work. Basturkmen **notes that teaching should focus on developing students'** knowledge of concepts as well as the language skills that accompany them. For example, the medical students need to be able to ask questions to elicit personal medical history. This may then be set as a course aim so that at the end of the course, students will be able to ask questions and interact appropriately when responses are given.

Thirdly, using a language for career-related purposes requires knowledge and understanding of career related and subject specific concepts. According to Basturkmen (2006), **teaching 'underlying knowledge' can be classified as cultural concepts and she mentions that underlying knowledge is essential for language learners to understand what is often referred as the 'invisible discourse' operating in** language. This refers to a **community's way of thinking and frames of reference when** producing and understanding the language. Therefore, a need to introduce learners **to the isiXhosa community's ways of thinking is an important part of professional** education.

Fourthly, as the theory suggests and as students mentioned during interviews, the teachers may be lacking second language teaching strategies. Basturkmen (2006:139) maintains that “teaching which is oriented towards the development of strategic competence should aim to make use **of the learner’s existing knowledge of the target language itself**”. Therefore, this notion highlights the various elements that the teachers can follow. But, the problem is that the teachers are not properly equipped to develop their own courses. I believe that the teacher-centred approach probably **had some negative effects on the students’ learning and certainly on their interest in isiXhosa**.

In the interviews it was clear that the students want to minimize the amount of time spent by teachers talking and instead give them more opportunities to practice. Students made it clear that they want to learn isiXhosa and are aware of the benefits of learning the language. They also made it clear that they preferred an interactive, communicative style of teaching with a variety of activities to maintain their interest. They said they preferred techniques such as pair work and role playing which would give them more ways of interacting with teachers and their peers.

Some of their comments were:

I would like to work in pairs and role playing because mixed approaches would bring life to the class and make more devoted to the lesson (S10, Bilingual).

Working collaboratively in pairs and groups I think would inspire us positively towards learning isiXhosa. We then would feel a real language setting. Unfortunately the teachers dominate the teaching without giving us an opportunity to participate which turns the classroom into a boring place (S6, Monolingual).

I would like group work and pair work because it will give us a chance to talk freely and gain self-confidence and so everyone can help each other in a different way. I think the problem here is that the teachers use the manual only. We rarely use other materials and we depend on the teacher to spoon-feed us (S4, Bilingual).

In the language classroom I believe in group work. It allows everyone to take part in the class. We do not feel inspired by teachers and their methods in isiXhosa lessons. I believe there are **really good ways of maintaining students’ positive attitudes** towards isiXhosa. Some students feel dull and passive in the class, because of teacher talking all the time and we are passive

recipients only. I believe that teaching determines the whole class situation either positively or negatively (S1, Monolingual).

Collectively, the students' seemed to believe that there are benefits and drawbacks in learning isiXhosa. But overall, they articulated clearly the need for active and motivating teaching and that the teachers' way of teaching shapes students' attitudes towards learning a language. The students reinforce the findings from the observations that the teachers tended to have a limited range of teaching techniques.

The interviews reflected to a large extent what I observed in the classrooms, regarding classroom management and pedagogy. Together the classroom observations and interviews showed that teachers seemed to put more emphasis on language accuracy instead of focusing more on keeping students interested, and achieving language competency. For example the isiXhosa students collectively agreed that the way isiXhosa is taught is different from the type of isiXhosa people use every day. They **said the teachers use "deep isiXhosa", which, perusing the manual, can be interpreted as outdated vocabulary.** By outdated I mean that it is no longer used because of a change in socio-economic times. Romaine (1989:55) notes that "loanwords are frequently used by people who immigrate to a new area and start to learn the dominant language of that area". When moving to a new setting, speakers will encounter a variety of experiences which are specific to the new environment or culture and will adopt readily available words from the local language to describe them.

This suggests that in urban settings in South Africa, deep isiXhosa is not used by isiXhosa patients. isiXhosa speakers substitute deep isiXhosa words for English ones not only to fill lexical gaps, but also to express emotions, states and attributes that have a particularly urban context and for which English lexical items seem most **appropriate and economical. An example of this is 'ithafa'** - which means toilet. This noun derives from a locative *ethafeni* - which means open space. Before the introduction to the modern toilets, people used the open space far from the homestead to relieve themselves. In some parts of rural areas this system is still in existence but

people now use terms like 'toilet' although they don't have 'toilet' in their language or homes. Another example is that of blood pressure, which is now commonly known in isiXhosa as '*high-high*'. However in deep isiXhosa the original word is '*uxinzelelo-gazi*', which is a descriptive phrase, combining the word '*xinzelela*', which means 'apply pressure', and 'blood', which is '*igazi*'. Lastly, the original isiXhosa word for a stroke in isiXhosa is '*ukufa icala*', meaning 'death on one side'. This meaning comes from the thinking that strokes always affect movement in one side. However, this word is no longer used and even isiXhosa patients now use the English word 'stroke'.

Recommendations

Therefore it is important that the materials and manuals that the isiXhosa teachers use reflects the modern usage of colloquial isiXhosa. These words provide but a few examples of the complexity of communication in student/doctor-patient consultation. The student-doctor needs to perform multiple tasks at once. She has to listen to what is said, draw on her acquired knowledge, formulate more questions and reach a conclusion as to what must happen next. All these are performed by a doctor in a short time. Therefore, in cases where the language can be simplified or made relevant, teachers need to update their conversational syllabus content.

Seven of the twelve students mentioned the following complaints and comments about the course:

- "isiXhosa is difficult and there were no supportive resources to help us outside the class"
- "Teachers were not making a special effort to make learning interesting"
- One student wondered if: "tutors cared enough for the students to understand the language or they were just doing their job or [whether they were] experienced enough to teach to a second language".
- "I usually waited for the teacher to give the answers instead of trying because the teacher never enforces rules"
- "I often copy everything from others"
- "Lessons were difficult to understand and I found myself thinking about other things"

- “There are never additional activities, extra orals or input besides the standard material”

Examining the Manual

In responses to the question, **‘Is the language level appropriate for you to understand?’**, the majority of students mentioned that they could not work with the manual without the teacher’s help. The majority of students found that the teaching materials were too difficult and that they could not tackle them without help. They also agreed that teachers spend too much time teaching the material rather than speaking with them. Students also indicated that there is a shortage of supporting materials. They feel that this puts them at a disadvantage. They stated that they memorised most of their oral assessment during their Objective Structural Clinical Examination (OSCE).

Thus with the students comments in mind, I decided to look at the manual, which was the only material the students were using. In doing so, I first checked what is the literature says about compiling a manual for language for specific purposes. Nunan (2003:79) “emphasises the importance of output and he argues that “we learn how to converse in a second language by having conversations rather than learning grammatical structures”. He argues that interaction should come first, and that out of interaction other aspects of learning would take care of themselves. Often then learners make use of various communication strategies in order to carry on with conversation. However, the students seem to be concerned about the difficult level of the language. Robinson (2005:8) notes that complex language constructions should be learned at a later stage because they require much more attention and effort from the learners.

On the same issue of a manual, Basturkmen (2006) writes that there are matters that need to be taken into account when designing a course and a lesson. The first is that learners need to be incorporated into the process of developing the topics they needed. She argues that if the syllabus is based on the needs of the learners, it acts as a motivational factor in their learning process. In this way, learners are able to see

the relevance of what they are taught. Moreover, because of time constraints linked with teaching this course, it seems sensible to design a course according to the important parts of the language that the learners would specifically need to know. Below is an example of a dialogue from the manual which would need a great amount of scaffolding to be suitable to teach the students at this level.

Example of a dialogue in the manual:

- Gqirha: Molo Mnumzana. Hello Sir
 Ndingugqirha Xaba. I am doctor Xaba
 Ndenza izifundo zobugqirha. I am doing medicine.
 Ndenza unyaka wesibini. *I am doing second year.*
 Mnumzana ndicela ukukubuza imibuzo embalwa. *Mr can I ask few questions.*
 Kulungile? *Is it fine?*
- Themba: Ewe kulungile gqirha qhuba. *Yes, it is fine continue*
- Gqirha: Ngubani igama nefani yakho? *What is your name and surname?*
- Themba: NdinguLungile Xaba. *I am Lungile Xaba*
- Gqirha: Ndiyavuya ukukwazi Lungile. *Happy to know you Lungile.*
- Themba: Enkosi gqirha. *Thank doctor*
- Gqirha: Lungile ndingakwenzela ntoni namhlanje? *Lungile, what can I do for you today?*
- Themba: Andiphilanga gqirha. *I am not well doctor*
- Gqirha: Mnumzana ungandixelela ngesigulo sakho? *Mr, can you tell me about your illness*
- Themba: Bendinomsindo, ndingxolisa umntwana, ndanesiyezi, ndawa. *I was angry, scolding a child, I felt dizzy, I fell*
 Ndazibona ndilapha esibhedlele. *I woke up here at hospital*
- Gqirha: Uziva njani ngoku, uyakwazi ukuthetha kakuhle? *How do you feel now, are you able to speak clearly?*
- Themba: Ewe gqirha kodwa intamo yam ibuhlungu, nesandla asibambi kakuhle. *Yes doctor but my neck is sore, and the hand does not hold properly*
- Gqirha: Uqale nini ukuyiqaphela le nto? *When did you notice this?*
- Themba: Ndiqale ukuyiqaphela kule veki iphelileyo. *I started noticing it last week*
- Gqirha: Ukhe wabona ugqirha ngaphambili? *Did you see a doctor before?*
- Themba: Hayi Gqirha. *No doctor*
- Gqirha: Zikhona ezinye izinto ozivayo? *Are there other symptoms you are feeling?*
- Themba: Ndikhathazwa yintloko gqirha. *I have a constant headache*
- Gqirha: Iba ngcono xa usenza ntoni? *What makes it better?*
- Themba: Xa ndingqengqe ebhedini. *When lying on the bed*

- Gqirha: Kukho abantu abanesifo sokuwa efemelini yakho? *Is there someone with stroke in your family?*
- Themba: Ewe utata wasweleka kukufa icala. *Yes my father was killed by a stroke*
- Gqirha: Uyasebenza? Wenza umsebenzi onjani? *Do you work? What kind of job?*
- Themba: Ewe gqirha ndiyasebenza, ndingumakhenikhi. *Yes doctor, I am working, I am a mechanic.*
- Gqirha: Ucinga ukuba isigulo sakho siyawuchaphazela umsebenzi wakho? *Do you think your illness affects your work?*
- Themba: Ewe gqirha kuba xa ndihleli ithuba elide apha esibhedlele andizi kuhlawulwa. *Yes doctor if I spent lot of time here I will not be paid.*
- Gqirha: Umqeshi wakho uyakwazi ukuba ulapha esibhedlele? *Does your employer know you are here in the hospital?*
- Themba: Ewe gqirha. *Yes doctor*
- Gqirha: Ingaba ikhona enye into ngaphandle kwezi uzixelileyo? *Is there something else except the ones you told me?*
- Themba: Hayi gqirha. *No doctor.*
- Gqirha: Kulungile ndisagqibile okwangoku. *It is okay, I am finished for now.*
Ndiza kukuxilonga sibone ukuba yintoni na ingxaki yakho. *I am going to examine you and see what the problem is.*
Usale kakuhle. Ndiza kubuya kwakhona. *Stay well. I will be back again.*
- Themba: Ndiyabulela gqirha enkosi. *Thank you doctor.*

As a second language teacher I found the Communicative Language Teaching Approach and Task Based Language Teaching very useful, because they put the emphasis on language use and fluency rather than language knowledge and structural correctness. Secondly, it encourages an environment that is interactive and not excessively formal, because as a teacher you are playing the role of a facilitator and participant rather than a traditional teaching role. The dialogue above is very long for second language learners, some of whom are attempting to learn a third language. It is also not structured in a way that students can work easily with it. It is constructed in a way that makes students dependent on a teacher breaking it down word for word. The vocabulary is not easy to learn and yet important in their path of learning. That is why the second language literature encourages teachers to introduce small chunks of new words, not to overwhelm learners with huge amounts of new vocabulary (cf. Chapter 2.2).

If I had to teach the lesson above to medical students, my goal would be to teach students language to converse to make it useful to them when they visit hospitals. Each lesson would need to serve practical purpose. The students would have to understand the lesson in context and not simply as a course which they will need to pass in the examination. Secondly, for each lesson they learn, the students would need to be exposed to the isiXhosa culture because I believe that learning a language is easier if the language and culture go hand in hand. By doing so, I would not just teach them to converse in isiXhosa but also to note cultural similarities and differences. The most important activity is to get them talking so they can learn to transfer their knowledge of vocabulary learnt in one context to another.

Therefore, I would divide the lesson into three parts. In the dialogue section I would add an administrator who would first ask the patient all the personal details and add a little bit about what brought the patient to hospital. The purpose would be to cover the personal information and not assume that the students understand it. It is also important to repeat the known language so that students can be engaged, enthusiastic and motivated. I believe students would then have the confidence to use the language without fears of making mistakes. Also with personal information it helps students to participate in the beginning of the lesson and put them at ease before tackling the difficult part of the lesson, which should come when the students have a better base in the second language. I would begin the lesson with the usual greeting in isiXhosa. As an isiXhosa teacher, at the beginning of every lesson I greet my students in isiXhosa. *'Molweni'* is the plural isiXhosa way of greeting as I walk into the class. They reply *'Molo'*. My next question is, *'Ninjani namhlanje?'* and they reply *'Siphilile enkosi, wena?'* **This ritual creates some sort of safety or shared space for students to create a rapport in the classroom.** This type of activity would also help the reluctant students to participate or take part in conversation.

The second part of the dialogue would be the consultation. This part would be the part that I would spend more time on because I view it as a core area of any isiXhosa Communication Skills lesson.

The first thing in the consultation section of the lesson would be pronunciation of all the difficult expressions about this particular consultation. Once I see the students understand the expressions better, then I would go through the dialogue word by word. Once the students understand the dialogue, I would devise exercises that would help them play around with this type of situation. For example:

1. Have the students listen to the conversation as the teacher reads the dialogue
2. Have the students read along to the dialogue with the teacher
3. Let the students read the dialogue themselves
4. Divide the class into three groups. Have one group play the role of the administrator, the other group patient and other group a doctor. In this area it does not matter how many mistakes the students make, as long as they are communicating, regardless of how broken it is, or how bad it is grammatically. I would rather hear them communicating than worrying about things like grammatical structure. Not all students like grammar and find it a very daunting area of language. In doing this exercise I would be using my pedagogical beliefs which are:
 - Catering for all students, including pairing them
 - Going from the known to unknown
 - Conducting small exercises, because with small exercises it is uncomplicated to do scaffolding. By creating many exercises students do not realise they **are being tested and there's no pressure when doing the exercise.**
 - Make the lesson student-centred, limiting my talking.

When doing exercises it **is important to monitor students' level of understanding by** paying attention to certain cues. For example if students are lost, they tend to get a blank or anxious look on their faces. Once this happens, the teacher needs to stop and revisit everything, because the students participate when they understand. In my view, the effectiveness in the use of exercises requires a teacher to be able to measure whether they are getting through to them. Once the teacher discovers that the students lack understanding then they must alter their approach and maintain a positive atmosphere in the class. A teacher needs to be passionate about the subject,

to encourage students all the time and to know the level of their abilities. Being flexible, patient and friendly are other attributes that help during facilitating so that the students are not afraid to make mistakes.

After the students have practiced the expressions and worked with some dialogue, the last exercise would be pairing them and have them practice relevant questions and answers. It is always useful to test students by asking them questions based on **the dialogue to check their understanding. For example, "Why does Themba visit hospital? When did he start feeling sick"?** The purpose is to build confidence in using isiXhosa, and I believe that it is best if oral exchanges occur between a student and their closest friends or peers, while the facilitator monitors and assists. The language learning in students involves copying, mimicking and listening. To give students a chance to hear themselves speaking results in them picking up certain expressions, and adopting them, and using them in different contexts.

Chapter Five: Conclusion and Recommendations

This chapter presents the summary, conclusions, and recommendations of the **research and considers both the teaching and learning issues and students' attitudes** towards learning isiXhosa. It also provides recommendations for teaching isiXhosa Communications Skills and ideas for future research. To acknowledge the reality of language communication barriers, the universities required among other things, a strategy of handling these languages carefully, in their commitment to overcome the language barriers. Despite the commitment in implementing the languages, there have been significant difficulties in students speaking isiXhosa and yet the numbers of patients speaking isiXhosa continue to grow rapidly as people move to the cities from the rural areas.

5.1. Research Questions

I will conclude this chapter by revisiting my research question, which is an exploration of Teaching and Learning in an isiXhosa Language Communicative Skills Course in the Medical School. I will address the themes of the research, hoping that the themes will address the questions. The questions are as follows:

What are the problems with teaching and learning in the isiXhosa Communication Skills Course in the Health Science Faculty? Specifically,

- (a) Why are students not acquiring enough competence in isiXhosa to be able to communicate with their patients?
- (b) To what extent is teaching and learning impacted by second language pedagogy?
- (c) What are language attitudes of students studying isiXhosa Communication Skills?

5.1.1. Research Findings

My research showed that although there are still challenges in gaining the basic level of proficiency, students think the course is essential in their medical careers. In investigating the reasons for the low level of proficiency, I found that students still lack confidence in speaking in class. I understand that second language learners tend to hesitate to speak when learning a new language because they are anxious and afraid to make mistakes. But still their confidence is very low. For example, in the

questionnaire survey, the majority of students ticked that they memorize the content in order to pass the exams, and are not able to actually speak isiXhosa.

Here are some of the findings that may be impacting isiXhosa language learning, resulting to low levels of proficiency in language learning and speaking:

- (a) isiXhosa is regarded as a difficult language to learn because it is different to European languages.
- (b) **Students' learning depends on their isiXhosa teachers as information providers.**
- (c) There is a lack of support for using isiXhosa outside of the classroom environment and in the community.
- (d) Learners have insufficient exposure to the language as there is a limited opportunity to use isiXhosa outside the classrooms
- (e) Students have limited vocabulary proficiency as isiXhosa reading materials are not always available.
- (f) Students have a negative attitude towards the target language.
- (g) There is not enough time in the isiXhosa Communication Skills tutorials for students to get good practice.
- (h) Students do not practice to speak isiXhosa with isiXhosa native speakers.
- (i) Some classroom environments do not fit second language classroom requirements.
- (j) The second language teachers are not well prepared to teach a second language, so they do not perform well and retain the interest of the students.
- (i) Students' lack confidence to use the language because they are afraid of making mistakes.
- (j) Old methods in teaching made the learning process dull and not interesting, so students feel bored and lack interest.

There was evidence during my observations that some students were not paying attention to the teacher and were drawing, eating chips or doing other things. The students participated very little in the class, and showed little determination and curiosity during the whole learning period. Instead the students showed more extrinsic motivation, such as wanting to practice medicine in South Africa and be able to communicate with patients. Some students mentioned that they were not capable of

learning the material taught in the class. Very little from the research showed that students were motivated about the actual language and about the class.

The students were reluctant to speak in the class. **Second language students' reluctance to speak in the classroom is a** problem commonly found in second language contexts. Students who have fewer opportunities to speak in the class tend to develop negative attitudes to class and are likely to lack motivation to put more effort in it.

The level of the tasks given to the students seemed too difficult for them. Students said that reading and understanding the manual was an important skill for success in acquiring a higher proficiency level, but they could not interpret the manual without the help of the teacher. If students do not know enough language skills, they will not be able to speak well or perform the tasks given, and this is one of the causes of **students' unwillingness to speak. Difficult tasks will not boost their self-confidence** either. Boosting their confidence can be done by creating various opportunities for classroom success in using spoken isiXhosa. A sense of success and high self-perceived communication competence can be easily achieved by students if easy tasks with clear and simple goals are used in the first place. The level of difficulty can be **increased over time as students' ability develops. General** goals should be broken down into smaller, short-term goals so that even when students do not achieve the final goals they still feel a sense of achievement for completing some of the sub-goals.

There is also a lack of vocabulary which results in low **proficiency. If the students'** vocabulary is low, confidence to speak will also be low. One gains new vocabulary by participating and using the language outside the class. There are no simple ways to learn a vocabulary. It also involves a great deal of practice, but it is rewarding when you understand and know the words.

The students appreciated the contact with real patients and were interested in understanding more complaints from a patient-centred perspective, and they credit that to the course. Involvement in clinical practice stimulated some motivation to learn and improve their language skills, and built their confidence in patient-centred

consultation. Some students mentioned in their interviews that there were advantages in meeting patients. From a socio-cultural perspective learning a language of the patient increase a student's feelings of personal accountability and involvement, and promotes their motivation for language improvement. The adoption of language communication skills is a complex process that involves practical experience from the teacher's side and constant motivation from the student's side.

5.1.2. Teaching of isiXhosa as a course

Implementing the inclusion of African languages into universities and schools poses many challenges, especially of isiXhosa. These challenges originate from the way that teachers were taught to teach second languages. In the past, there were negative attitudes towards the use of many black languages. Languages like isiXhosa were not popular and teaching courses for it are still underdeveloped, compared to English and Afrikaans.

There is still a lack of resources such as books, materials and teachers suitable for second language isiXhosa learning and teaching. Teacher Training Colleges and Universities, which were the only teacher-training institutes available in the past, were training teachers to teach first language learners, at primary and secondary schools. There was little or no attention focused on second language teaching in tertiary education, which the language programme designed by UCT required. Both teachers and students were entering an unfamiliar territory that needed space and proper plans for development to address the challenges.

When the courses started one would have thought that the communication barriers would be easily dealt with; patients would be happy because the doctors would be learning to speak with them in their own language while doctors would be finding diagnosis less difficult. But this is not the case. Over the years a number of professionally-orientated language programmes have been implemented and yet students still lack competence in speaking isiXhosa. The classroom observations and interviews showed that teachers seemed to place more emphasis on language purity, instead of using the common *lingua franca*. There is nothing wrong with this style of

teaching, but it is better when this style is used with an interactive, communicative approach. The teacher-centred style does not encourage spontaneous interaction.

5.1.3. Teaching Issues

My research also showed that teachers have challenges with second language pedagogy. Teaching strategies are significant in second language acquisition because they provide tools for gaining skills and achieving goals. Teaching strategies can facilitate **specific aspects of the student's competency, such as communication proficiency**. But if students are using a narrow range of learning strategies, there will be problems in learning and gaining satisfactory proficiency levels. In my experience, second language learning success depends largely on good language teaching strategies. The teacher needs to build a supportive learning environment in the classroom. Once students feel a sense of support from their teacher and peers, it is likely that they will be more willing to speak in the target language. For example, allowing students to speak in groups with their peers before offering them to the whole class encourages students to speak and gives them more confidence in speaking isiXhosa. There is a need for students to understand the reasons for learning language communication skills in the early years of their medical career for motivation to learn. **Previously the students were not trained to learn and value the patient's language as an important tool to formulating a realistic healing strategy with the patient.**

According to my observation the quality of isiXhosa language teaching was not satisfying the needs of medical students. Several factors contribute towards this. Implementation of teaching and learning isiXhosa still has shortages of resources and unqualified teachers to teach it as a second language. Since group work for language learning is not widely used, teacher-centred classrooms are common. Some classes are not equipped for group learning, because their setting is in a form of a lecture **theatre, which limits the teachers' movement and space for grouping. The low usage of group work could be one reason for low proficiency for students.**

There were also pedagogic concerns on the side of the teachers. These pedagogic features seemed to be missing a lot in the classroom during my observations of most

teachers, and the students highlighted a few examples in their interviews. Although it is difficult to generalize across the observations, it seemed that none of the teachers used the communicative and interactive approach. Traditional methods of teaching that do not encourage spontaneous communication or interaction in isiXhosa still exist. Teachers still relied on translating dialogues in the manuals, with little interactive activities and attempts at sharpening communicative skills of students. Students still lack motivation and interest in learning the language. Some students do not appear to be serious about increasing their language competency. It was not surprising to see a lack of language fluency among medical students from non-isiXhosa speaking backgrounds. They reported that they encountered difficulty with the complexity of the language. Therefore, although language skills can be taught and learnt in a course, they are easily forgotten if not maintained by practice.

5.1.4. Students' attitudes towards learning isiXhosa

My research findings on students' attitudes and perceptions as reflected in the interview data shows that some students are critical of learning the isiXhosa Communication Skills course at the beginning. This is because they saw the course as not benefiting them. Medical students struggle with developing and improving their language communication skills. Their criticism is directed to the way the course is taught. The students wish to frame questions in isiXhosa, talk to their patients and be polite to their patients, but they lack the communicative skills that are crucial for interaction in the classroom and in hospitals. There is little practice happening in the classrooms. Yet language learning demands lot of practice, hence giving simple, precise learning strategies will help students go beyond classroom learning.

Students working with patients need to develop a caring attitude towards the patients as well. However students mentioned that when confronted with patients who speak other languages like isiXhosa, they still have feelings of helplessness towards them because they cannot speak their language. Yet there is still a lack of motivation and effort in acquiring proficiency in the classroom. The teachers are not doing enough to get the students to speak efficiently and students not putting additional effort to learn. This kind of learning demands language skills awareness i.e. listening skills,

pronunciation skills and speaking skills. As the course proceeds, students should continuously develop these skills. Later they can develop several communicative skills, where they will learn to apply certain kinds of questions, formulations of opening **questions, and understand shifting between patients' personal history and the minimal** exploration of symptoms.

The teaching should include typical interview situations, typical communicative behaviour and typical complaints that patients have. These strategies will help students develop confidence and positive attitudes. It is also important for the teacher to help students to realise that even if they may see no need to become proficient in a second language, the learning of isiXhosa language and culture can only enhance their understanding and change their perceptions about their patients. Therefore teachers need to be practical in teaching these students by identifying the key themes related to learning isiXhosa.

In conclusion, the findings based on the study clearly indicate that UCT Medical students still lack of many key factors to support them to learn isiXhosa effectively, such as motivational encouragement, good learning strategies, and effective teaching strategies. The different pedagogical styles of teachers are a reflection of differences in training and experience. The typical pedagogies of the teachers no doubt are based on traditional, grammar oriented, teacher-centred pedagogies that the teachers would likely have experienced as learners themselves. The teachers would not have had the advantages of having more resources, teaching materials, training and exposure to a variety of theories of learning and teaching.

5.15. Retraining of teachers

Despite all the challenges mentioned above, students want to communicate with their patients in their language. Therefore, solutions are needed to make this programme successful. Retraining of teachers might be a solution. Special attention should be dedicated to second language teaching training. Specialised methods of language teaching have to be accommodated in order to respond to professional needs of the learners. Specialised teacher training for language teachers needs to be developed

and networking between such institutions should be encouraged. That success needs to start with teachers, the quality of their teaching needs to be strengthened, and the teachers require motivation in their hard work because they are the people who hold the knowledge and are the ones who can get the best out of the students. Given the language learning problems that affect learners, stakeholders and teachers should try to find ways to solve the acquisition and pedagogic problems. It is important that language facilitators should recognise that such problems are a main cause of **students' low proficiency levels and negative attitudes. Teachers learn much about teaching through practising their teaching.** They need to think about what was successful about their lessons and what needed to be improved. They should think about their students, those that are doing well and those who seem to be having difficulty. They can do all this by reflecting on their teaching, and think of ways in which it can be improved. It is therefore recommended that there should be cooperation amongst second language teachers. Experienced second language teachers can help with the methodological approach to improve second language teaching. Teachers should be trained, tested by their peers and given feedback, on **what the teachers' strengths and weaknesses** are.

5.1.6. Pacing of lessons

Training and feedback from peers should also focus on issues of pacing of lessons. Pacing a lesson needs to be present in every decision in the day-to-day practice of the classroom, since time is a constant element of the class. Teachers need to ask themselves this such as: How long do I spend on an activity and how long should students spend talking to each other during group activities? (Time allocation), How do I end one activity and start another? (Changes), How do I present an activity to students? (Framing), What tools can I use to help students understand my presentation of the activities they are supposed to do? (Scaffolding), and How do I make the different activities of one class fit together? (Sequencing).

Each of these elements plays an important role in how the activities of the class hour are stitched together. Teachers should be advised as to how they could improve, and how effective the pacing of their lesson was. They should also consider how much of

a chance the students had to speak and what they noticed from their teaching. The teachers can then think about what they should do next time to improve their teaching. The teachers need to develop instructional strategies to meet the needs of the medical students. Should they be taken into consideration, the recommendations might yield a shift from the challenges highlighted in this study towards bettering the learning in isiXhosa for these students.

5.2. Design of the course

Another area where teaching could be improved involves the way in which the course is designed. I think effective design of a language communication skills course **demands a knowledge of students' common problems. New approaches could be** gained if previous students were consulted. It would be helpful to explore whether **students' level of expectation align with the course outcomes. These questions can be** answered through research.

In order to help students cultivate an awareness of language learning strategies, teachers may introduce them to the wide range of alternative strategies, help them understand their current strategies, and assist them to find the circumstances under which a given strategy can be applied effectively. Learners naturally mature into using different strategies at different times. Therefore it seems reasonable to introduce a variety of strategies and let them choose which ones are right for them. Effective strategy use may consist of the flexible use of the right strategies in the right task. In other words, teachers may introduce the learning strategies and demonstrate how to **use appropriate strategies to meet students' needs in different learning tasks. For** example, the isiXhosa medical language vocabulary should be mainly composed of consultation, examination and giving advice. Teachers may help students develop strategies when teaching each area. These learning strategies should be practiced often in different learning tasks. It is only through frequent practice that students will become more familiar with these learning strategies.

The process of communication skills training for teachers involves continuous shifting between teaching improvement, practical training and self-evaluation. This kind of

teaching demands monitoring and evaluating the course constantly. As students develop several language communicative skills, the teacher needs to create realistic scenarios where students can apply them. In order to make the language learning process a more motivating experience, instructors need to put a great deal of thought, time and effort into developing lessons which maintain student interest and have obtainable short term goals.

It is important not to rush these students into dealing with demanding language contexts without a language base. Indeed, the goal is for students to communicate with their patients. But we must remember that majority of these students are learning and hearing isiXhosa for the first time, hence solid language foundation is required to expose these students to the isiXhosa language structure, and that cannot be done in isolation, it should be integrated into context. The language must be pitched at a right level for these students, which is a basic level, in order to build confidence and competence that would encourage and motivate students. The curriculum needs a buy-in approach from the students, where they first enjoy the language in a stress-free environment, and gradually build on from that.

The two contents, isiXhosa language and medical content cannot be taught at a same pace. It would be extremely difficult for these students to achieve expected objectives like, language, cultural, cognitive, content and environment at the same time. The curriculum is putting pressure on the students, and not helping the delicate development of the isiXhosa language to take its path because students will tend to identify the medical curriculum as more critical than the language curriculum and yet these two play different roles in the development of better health care.

Language training for the medical students could be developed into different stages. Their training should begin by focusing on straightforward skills for patient-doctor interaction, such as basic human interaction, and gradually move towards consultation training. For example:

1st phase: Basic Communication Skills in human interaction. During this phase they would learn basic personal communication skills, role-play with each other and watch videotapes. The purpose would be to listen and pick up cultural cues.

2nd phase: This should use real life exercises, by taking two illnesses that would generate a basic consultation. This phase will focus on asking and responding to questions. This is where you can group certain illnesses according to language patterns, for example, illnesses like (intloko-head, intamo-neck, ingalo-arm/ isisu-stomach/isifuba-chest/ umqolo-back umlenze-leg). These are generic illnesses that can help students to derive certain patterns in asking questions. It would then become easier for students to pick up the patterns in asking questions.

3rd phase: In this phase, students could use case studies where they practice how to ask questions from those cases.

After these phases, pairs of students can perform simulated consultations with patients, where they conduct a complete history taking and physical examination. The repetition of these exercises is crucial because it gives students confidence. Taking the patient perspective is useful in understanding the thinking and feeling of a patient. Simulated patients can come in to make the roles more realistic and to build students confidence before they meet actual patients. A good foundation in learning a language is very crucial because it minimises anxiety. An effective language process requires a diversity of methods. Finally, recording videotapes of the students doing consultations **gives teachers and students a good idea of the student's performance.**

After each lesson students need to demonstrate their abilities through assessment. Two examiners can rate the student and come to a final assessment of the student through discussion. All this should be happening in a relaxed environment because this is the most important aspect of learning a new language. Rehearsals lead to better acquisition. The most important point is that communication is rooted in a patient - student and -community oriented curriculum and that communication skills should be seen as core elements of good doctoring. Videotaped materials can be introduced in

every scenario where students can watch the demonstration and then simulate it. In this concluding part I will therefore make some brief recommendations for the programme curriculum designers.

5.1.2. Challenges

It is important students to recognise and integrate the importance of isiXhosa in their practice. But the adaptation of materials to the language of medicine creates challenges for teachers and places demands on students who have had little exposure to the isiXhosa communities. Adaptation would require teachers to simplify the content to the level of beginners and for conversational purposes. Lastly, during assessments, the students are required to perform a language outcome while conducting the actual diagnosis. This creates language demands on students if they have not been given a solid isiXhosa language foundation, and some students are learning isiXhosa for the first time at medical school. In these pressurised learning situations it is difficult to blame students for rote learning because it is their coping method of learning the language. There is pressure all around for these students. Therefore, I would strongly suggest that the curriculum should be revised to give these students a fair chance to gain competence at the end of the course.

5.1.3. Recommendations

This research highlights that students who are involved in human-interaction professions may need to do basic and general communication skills before they focus on specific purposes. Language for specific purposes requires teaching methods designed to meet specific professional needs. Therefore, it is important to integrate the language learning and subject learning approaches.

Generally, emphasis is put on the practical outputs of language learning. However in this method, the basic language skills are lacking. Students need a basic introduction in the language, which I call a start-up vocabulary. This is a general service vocabulary that is common to all domains. Once the students obtain good general isiXhosa skills, they will be more able to master specific isiXhosa skills needed in a specialised field requiring professional communicative skills.

Once the basic skills are learnt, experienced teachers can use their professional experience to mix basic language skills with medical content in language specific teaching. If the teachers have some knowledge of the subject matter, they can choose appropriate learning materials that meet the needs of medical students. As the language teacher, they are required to be the organiser, course manager, monitor, adviser and facilitator. The teacher is also the course planner and material provider.

Meeting students' needs is done by knowing the different ways in which students acquire language. Syllabus design plays an important role in any level of curriculum. In designing a curriculum a teacher needs to look at three key teaching developments: needs based programming teaching, competency-based language teaching and genre-based language teaching. He continued to mention that teachers should analyse the needs of their students and negotiate language learning objectives with them at the beginning of the course. In order to balance all these, teachers need to possess a great deal of flexibility and be interested in the professional activities in which the students are involved. Above all, teachers should be willing to be challenged and be armed with a sound knowledge of both theoretical and practical developments to empower them to make good decisions. However, teachers still need to encourage students to become responsible for their own learning.

5.1.4. Classroom strategic communicative competence

isiXhosa is a complex language for beginners. Students learning isiXhosa as a second language are confronted by a different syntactic complexity compared to English and Afrikaans. Thus an instructor of a second language needs to have a method of teaching in mind that will suit the purpose of the classroom. For example, when using Communicative language teaching, an instructor would need to understand the following strategies:

- *Commitment to using the language for classroom communication as much as possible.*

In this way the teacher builds student confidence in using isiXhosa and the students are exposed to hearing and using isiXhosa as much as possible in the classroom.

- *Focusing on language use regardless of whether the isiXhosa used is correct and pure.*

Fluency is reached by encouragement and negotiation of meaning between students and teacher. Materials need to be authentic, with lots of talking activities.

- *Create an environment that is interactive, not excessively formal, encourages risk-taking and promotes student freedom.*

Teachers need to favour relaxed, informal, positive and non-threatening environments, because these make the second language classroom more productive and encourages students to interact. Teachers should play the role of a facilitator i.e. offering suggestions, steering students in the right direction and responding to their needs when they are engaged in task work or group work.

All the issues mentioned above show that there should be structures in place that monitor the teaching of second language courses designed for specific purposes. As these languages now have become part of the curriculum in the medical field, the students need to fully understand the reason for the courses before they embark on them. **The institutions and teachers cannot assume that students' language** perceptions and negative attitudes will disappear. Indeed, this thesis has found that students see the relevance of good communication skills for medical practice but still do not value the communication skills component in the curriculum in their early years.

Teachers' second language teaching skills can be improved by strengthening the training and conducting teacher's development workshops in second language teaching. This means that teachers and course designers need to be aware of certain proficiency and knowledge objectives, which can be divided into linguistic, cultural, grammatical and affective objectives. The course designers need to see that the course has the potential to improve **students' proficiency by focusing on students'** needs through specific features. Language communication skills should be based on what works for both students and teachers.

5.2. Recommendations for an integrative communication curriculum

My research shows that a rethinking of the medical curriculum design should be considered to alleviate pressure on the medical students. Making adjustments that are related to language implementation could make all parties less frustrated. We must remember that language skills integration into the medical curriculum was done for a reason: for better communication between patients and doctors. Learning to talk with patients was a major goal of the language communication skills course in the medical curriculum. Language acquisition has been integrated into the medical curricula in the form of communication skills training which is based on a patient-centred care.

However, acquiring a language communication style that recognises a patient as a person, responding to the **patient's complaints in an empathic way, and giving a diagnosis** is a complex task. Many students experience the integrated language content of patient-centred care as a challenge that can cause distress and even negative attitudes towards the language. Therefore, I recommend that the language teachers and the faculty work together to make a concerted effort to change these negative attitudes and perceptions of students, through improving the teaching of the isiXhosa language Communication Skills course. The medical curriculum in the early years has its pressures because the students are still finding their feet. Hence a good grounding in basic language skills is important because general service words are the bones on which the meat of the medical vocabulary hangs. This is what the first year teaching should focus on. Simply teaching the medical students the medical vocabulary will not allow them to use it because they do not know the grounding which supports their specialist vocabulary.

Nevertheless, it would be misleading to assume that a small basic vocabulary would be enough. Second language learners have to practice their vocabulary outside the classroom when meeting people and so on. The aim is to build at least a solid foundation for a language before it is used in context. In order for learners to be able to say or write anything they need a framework to put words into.

5.2.1. Proposed curriculum framework:

The first year will give time to acquire basics which should help students to understand language patterns, basic structure and cultural aspects that should give them confidence in the second year because learners are not going to get very far without large basic vocabulary. The second language learners do not have the benefit of a huge listening vocabulary to start using it. This vocabulary needs to be built from scratch. The second language speaker does not have grammatical patterns in place to hang new words, and this also has to be learned. Therefore, it is probably more effective to teach the basic vocabulary first to enable learning to take place. The first year course would thus involve: Basic language skills, during this year the learning objectives are three-fold: speaking, listening and rehearsing, especially personal information. This will give the students the practicing time so they can improve their listening skills and pronunciation, build confidence and familiarise themselves with the **language. This is a stage where the teacher's pedagogic experience comes into play,** because the teacher needs to equip students with second language learning strategies.

In the second year, learners should feel more empowered, and feel that they can do things with the language. The start-up vocabulary should allow the students to manage their own learning better. Now teachers can implement small packages of vocabulary that relate to the medical context. They can then use the new medical vocabulary with the language patterns they acquired in the first year. The second year course would still involve basic language skills and medical language vocabulary, but **would also include taking a patient's medical history. This year the students should be** practising putting the social and medical history together. I feel that **taking a patient's** history is the most important skill in medicine that the students need to be encouraged with, because it is the cornerstone of clinical diagnosis and the foundation for the doctor–patient relationship. The language patterns learnt in first year will help students to guide them when learning different illnesses. It will also help students to get to know patients, win their confidence and understand the social context of their illness. This should be done through a process of listening, where the students allow

patients to tell their story in their own words, and then clarifying the story to see gaps in the story. The questioning process is where the students focus on certain areas of relevance. During this year they explore themes to go along with the objectives of the first year. Practice plays an important role in improving language skills, so opportunities for practice would need to be created.

In third year, the students can start role playing their medical consultations because they should now have a large vocabulary bank to construct questions with and understand some responses. The medical terminology should be used with confidence by students, but still focus on case studies as their practicing and confidence platform. The students can also start visiting clinics twice or three times a year to start the real interaction with patients. This time the students will be confident with the first part of consultation which is history taking and family history. The students would have been equipped with various coping language strategies.

In fourth year, the students should be confident enough to go to the hospitals to talk with patients in isiXhosa. The focus should be on vocabulary to develop their talking skills further. The language patterns they have learnt should help them construct questions about different illnesses. Now the students should focus on dealing with emotions and giving support to their patients. In other words, they should be able to integrate language and content. The students should be making videotapes of real consultations that they have conducted, which can be analysed by their peers and teacher, in order to evaluate themselves.

The fifth year could replicate the fourth year, encouraging the process of practicing and nurturing language communication skills. Most importantly, isiXhosa language communication needs to be embedded in the patients, students and community.

5.3. Conclusion

In conclusion, adjust the teaching of the language skills at UCT, so that the teachers can plan appropriately, and students can be satisfied and a better match between students and teachers is achieved. New methods of teaching languages should be

promoted in order to motivate learners to speak. Language learning must be learner-focused, better geared to both basic and professional contexts. This will improve learner motivation and the successful competence in the classroom and professional field. This, in turn, will be to the benefit not only of learners but also those looking to employ students who are properly trained to assume their professional responsibilities. The time and effort invested in language learning and teaching programmes might be wasted unless language skills are gained throughout the learning pathway. A second language is a valuable complement to any professional field.

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APPENDIX A

Questionnaire

Questions about yourself

(All the information will be treated in strict confidence and will be used only for research purposes)

1. Age:
2. Sex:
3. School attended:
4. Level of study at UCT:
5. Languages you mostly speak at home with family?
6. Which other languages can you speak?
7. With the following people, which language are you more likely to speak?
Parents, friends, patients, siblings, mentors

Second Part

(Please, indicate your answer with a tick in the appropriate box, you can also add a brief comment, if you want)

1. More should be done to promote languages in University.

☐☐☐☐

Strongly agree

agree

disagree

strongly disagree

Explain

2. Learning a language may be important to my future goals.

☐☐☐☐

Strongly agree

agree

disagree

strongly disagree

3. It is a mark of respect to people to learn their language if you are providing them with health care.

☐☐☐☐

Strongly disagree

agree

disagree

strongly agree

4. It is important to understand peoples' culture and value systems before providing them with healthcare.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Strongly agree	agree	disagree	strongly disagree

5. It may be an advantage to my career to be able to communicate in another language

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Strongly agree	agree	disagree	strongly disagree

6. Feelings and emotions can be expressed more effectively in English than other languages

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Strongly agree	agree	disagree	strongly disagree

7. Learning a language in tertiary education should be a voluntary thing.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Strongly agree	agree	disagree	strongly disagree

8. The solution to the language problem is for all patients to become fluent in English so that doctors can communicate with them

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Strongly agree	agree	disagree	strongly disagree

9. The isiXhosa communication skills course has been effective in making me more communicatively competent in the isiXhosa language

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Strongly agree	agree	disagree	strongly disagree

10. This language course has been run in a well organised manner

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Strongly agree	agree	disagree	strongly disagree

11. Material was clear and concise

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Strongly agree agree disagree strongly disagree

12. I have to study regularly if I want to do well in this course

☐ ☐ ☐ ☐
Strongly agree agree disagree strongly disagree

13. On this course it is possible to do well without studying much

☐ ☐ ☐ ☐
Strongly agree agree disagree strongly disagree

14. The course was fun and I enjoyed it

☐ ☐ ☐ ☐
Strongly agree agree disagree strongly disagree

15. There have been sufficient resources in the library to support my learning.

☐ ☐ ☐ ☐
Strongly agree agree disagree strongly disagree

16. I only study things that are going to be covered in the assessment.

☐ ☐ ☐ ☐
Strongly agree agree disagree strongly disagree

17. Preparing for language assessment is a matter of memorising.

☐ ☐ ☐ ☐
Strongly agree agree disagree strongly disagree

18. I probably forget most of the language skills I have learned after the assessment.

☐ ☐ ☐ ☐
Strongly agree agree disagree strongly disagree

19. The assessment has been appropriate for the course aims.

☐ Strongly agree ☐ agree ☐ disagree ☐ strongly disagree

20. The assessment has been fair and reasonable

☐ Strongly agree ☐ agree ☐ disagree ☐ strongly disagree

21. Select a word which best describes you in the doctor-patient relationship after you have completed isiXhosa classes

- ☐ improved
- ☐ unchanged
- ☐ greatly improved
- ☐ worse

22. How important do you think doctor-patient language communication is for doctors?

- ☐ not important
- ☐ quite important
- ☐ essential

23. Would you describe yourself as:

- ☐ Monolingual
- ☐ Bilingual
- ☐ Multilingual

24. Which of these statements best describes the way you feel about language communication skills in the medical curriculum?

- ☐ Strongly in favour
- ☐ Somewhat in favour

- ☐ No particular feeling
- ☐ Strongly opposed

25. At what stage should language communication skills be taught in the medical curriculum?

- ☐ First year
- ☐ 2nd year
- ☐ 3rd year
- ☐ 4th year

Give reasons for your answer

26. Rate the importance of these languages in the medical curriculum, 1=good, 2=fair, 3=not too good, 4= bad

- ☐ English
- ☐ Afrikaans
- ☐ IsiXhosa

Give reasons for your answer

27. Which of the following words best describes your feelings about isiXhosa classes?

- ☐ Interesting
- ☐ Boring
- ☐ Relevant
- ☐ Irrelevant
- ☐ Difficult
- ☐ Easy

APPENDIX B

Interview questions for the study

1. To what extent is absence of a language a barrier in your work? Explain
2. Do you **understand enough about the patient's illness/pain/ problem?**
3. How are you enhancing your communication skills?
4. Did you enjoy the isiXhosa course?
5. Did you wish to have learned more about language or the culture?
6. Any regrets from the past concerning language? Do you have regrets about anything relating to your isiXhosa course? If yes, explain
7. Are you satisfied with the way the course is taught?
8. Is the language level appropriate for you to understand?
9. In hospital, which patients do you feel comfortable speaking to? Why